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## Table of Contents

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ORIGINAL ARTICLES—	Page	BRITISH MEDICAL ASSOCIATION—	Page
An Address—Thoughts of a New President, by Bertrand A. Cook .....	873	New South Wales Branch: Annual Meeting ..	896
Seasonal Epidemics of Endemic Goitre in Tasmania, by H. B. Gibson, J. F. Howeler and F. W. Clements .....	875	<b>CONGRESSES—</b>	
Management of Hand Injuries in Group Practice, by Gordon Trinca .....	880	Victorian Cancer Congress ..	906
"Squaline" (Fluphenazine) in Psychiatric Practice: A Preliminary Report, by Harry R. Bailey, J. S. Blow, and S. G. Sandes .....	885	<b>OUT OF THE PAST</b> ..	907
Prognostic Significance of the Serum Protein Content in Premature Babies and Its Relation to Pulmonary Hyaline Membrane: Preliminary Communication, by W. D. Domville Cooke ..	887	<b>CORRESPONDENCE—</b>	
		A Fortunate Juxtaposition ..	907
		Surgery and the General Practitioner and Pro- fessional Unity ..	908
		<b>OBITUARY—</b>	
		Lindsey Page Winterbotham ..	908
		Archibald Hector McIndoe ..	909
		Robert Charles Espinasse Brodie ..	909
		<b>POST-GRADUATE WORK—</b>	
		The Post-Graduate Committee in Medicine in the University of Sydney ..	910
		Royal Prince Alfred Hospital: Ear, Nose and Throat Department ..	911
		<b>NAVAL, MILITARY AND AIR FORCE—</b>	
		Appointments ..	911
		<b>DISEASES NOTIFIED IN EACH STATE AND TERRITORY OF AUSTRALIA</b> ..	911
		<b>UNIVERSITY INTELLIGENCE—</b>	
		The University of New South Wales: Appointment of Professor of Physiology ..	911
		University of Sydney ..	911
		University of Melbourne: Faculty of Medicine ..	912
		<b>NOTES AND NEWS</b> ..	912
		<b>NOMINATIONS AND ELECTIONS</b> ..	912
		<b>DEATHS</b> ..	912
		<b>DIARY FOR THE MONTH</b> ..	912
		<b>MEDICAL APPOINTMENTS: IMPORTANT NOTICE</b> ..	912
		<b>EDITORIAL NOTICES</b> ..	912

### An Address.<sup>1</sup>

#### THOUGHTS OF A NEW PRESIDENT.

By **BERTRAND A. COOK**,  
*President, New South Wales Branch of the  
British Medical Association.*

I AM deeply conscious of, and grateful for, the honour that the New South Wales Branch Council has done me in electing me President for 1960. Many distinguished men have occupied this chair, as you can confirm by looking at the portraits that adorn this hall. They were leaders not only in the medico-political spheres, but in the various specialties and general practice as well. They laboured ardently to resolve the difficulties that beset the profession in their time, and to help the art and science of medicine. Great as their difficulties may have been in the past, I do not believe they were as great, complex or pressing as the present-day difficulties we are facing. This impression is shared by many men who have served on this Council for lengthy periods, and whom you know well and respect for their great service to the Branch. But our privileged place in society attracts difficulties and troubles;

<sup>1</sup> Read at the annual meeting of the New South Wales Branch of the British Medical Association on March 31, 1960.

to paraphrase the Bible, we are born unto trouble as the sparks fly upward. It was ever thus, it will always be so. For we are, as it were, by training, tradition and the nature of our work, a race apart. We are never really completely integrated into a community. Individually, we are respected, liked, even loved by our patients in the main; but too frequently, our reward for honest endeavour and sacrifice for the sick is none other than sheer ingratitude. Nor is this a new development in the doctor-patient relationship. Over four hundred years ago, John Owen (1560-1622) noted it in this epigram:

God and the doctor we alike adore  
But only when in danger, not before;  
The danger o'er, both are alike requited,  
God is forgotten, and the doctor slighted.

Collectively, we are treated with suspicion. Our motives are often questioned and suspected by the public. Often we are not given credit for worthy motives, and our ethical standards, because not understood, are assailed and given a sinister interpretation. Politicians understand this foible of the public very well, and they are wont to play on these fears, suspicions—yes, even jealousies—of the electorate for very unworthy motives. For, numerically, we are contemptible from a franchise standpoint, and ethically, we are handicapped in defending ourselves. Indeed, it is obvious that in many parts of the world, doctors are a pawn in the political game, especially where there are so-called free health services. In these a common pattern emerges. The doctor is always called on to sacrifice more

for the common good than any other section of the community. He is sacrificed not only financially, but also in what is more precious to him—namely, his professional liberty to decide what is best for his patient's treatment as his training and experience would indicate. In England, it seems that dentists and chemists fare much better. In Australia, also, pharmacists, whilst not completely happy with the new scheme, are treated more favourably than are doctors.

#### The Association and its Activities.

On this occasion, whilst noting some present-day problems and trends, I thought it would be useful to say something about the Association, its government and its current programme; more especially, as we are glad to have with us this evening a good number of recent graduates, who may not be aware of these things.

As you see by the annual report, we have 4310 members, representing the vast majority of doctors registered in this State. Of these, some 25% are in salaried service of some kind; about half are government employees. Ignorant people often call us a trade union, and, if they are not fond of us, at least they respect us for the strength that a trade union affords its members. We are really a professional body, bound together for certain purposes laid down in our Articles; but, also, we are registered as a public company, and as an employer under the *Arbitration Act*, so that we are bound by the provisions of the *Companies Act*. By extension, therefore, we may say that our members are the shareholders, and the Councillors whom you elected this evening, the Board of Directors. Our business is conducted by the Council, which, at its first meeting, divides itself into a number of committees, called the Standing Committees of the Council, namely: the Executive and Finance Committee; the Ethics Committee; the Medical Politics Committee; the Hospital Committee; the Organization and Science Committee; the Public Relations Committee. Every matter coming to Council for consideration will normally be debated by its appropriate committee first, and a recommendation will be sent on to Council. Council does not always confirm such recommendations, and often reverses them, in its wisdom. The important thing to remember is that every important problem will be debated at least twice before a decision is reached.

You will have noticed, by the balance sheet, that our material assets are very great indeed; we have a property asset in this building worth at least £400,000, upon which a debt of a few thousands only remains. But the most important asset that we have does not appear in the balance sheet. It is an intangible asset—namely, the character, integrity and loyalty of our members. The great majority of our members conform to a high standard in this regard, but, like every cross-section of society, we have a small minority who are aberrant. Unfortunately, the conferring of a medical degree will not give a character to a graduate who did not have one to start with. This is where our ethical standards, our education and the force of good example must play its part. This provokes the thought that some people are wont to remark that we do not discipline our members. This is not true. By-law 20 deals very thoroughly with penalties for breaches of ethics and unprofessional conduct, and its severest sanctions—namely, expulsion and the prohibition of our members having professional relations with such people—have been invoked from time to time. Of late years, however, by an amendment of the *Medical Practitioners Act*, this supreme penalty is declared null and void, and any society attempting to implement it shall be deemed liable to a penalty of £50 on conviction. This is not to say, however, that Council does not cite offenders under the ethical code. This happens frequently, and I am glad to tell you that we are usually able to effect our purpose under our present powers.

Let me now say a word about the Council—that much maligned, misunderstood and often abused body of men, who offer their services for the betterment of their confrères in the profession. They comprise some of the busiest men in medical practice, and after their day's work with

their patients is done, they forgather here, night after night, and far into the night, dealing with the many problems that we have to face. They are dedicated people, who take time and pains to make themselves thoroughly conversant with these matters, before taking a decision. So, please, when a desired objective is not obtained by Council, do not ascribe it, as some of our critics are wont to do, to ineptitude, incompetence or sheer ignorance and stupidity. A decision having been reached, the matter is then dealt with, under the supervision of the Executive, by the Secretariat. In simple justice I should say, too, at this stage, a word about our Secretariat. We have a magnificent team serving us behind the scenes. They get no limelight for loyal, devoted service to the profession. Often their hours are longer than any general practitioner's. The senior medical secretaries have spent the best part of a lifetime in this office. The profession deserves well of them, and Council is paying attention to more adequate remuneration for them, having regard to the altered value of money, and to the rewards got outside these days by very junior graduates. Two very fine recruits have joined the staff recently. They promise well, and when the seniors, as they must in the effluxion of time, lay down their burdens, these men will carry on a like tradition of service.

Council has always been anxious to promote the unity of the profession. It would like to weld all sections into a solid, cohesive body. That is our only strength. This objective is not easy to attain, on account of the many divergent sections, each with its own set of problems, which differ from all other sections. All must, however, look to the Council as the only negotiating body, after appropriate briefing. There must never be a break in the ranks, or a cleavage, like that which proved so disastrous in England. That way would lie disaster for us.

#### Public Relations.

Of recent years a vigorous programme of public relations has been pursued. Not a slick, commercial type of sales-talk, mind you, but honest, factual presentation of our aims and objectives. This can be roughly divided into three categories:

1. Between the profession and the Council. By visits to Local Associations, by diffusion of important information and, we hope, by more active participation of delegates in quarterly meetings of Council, do we hope to bridge the gap between members and the governing body.

2. Between the Association, the Press and the general public. For some years now we have carried on a Press service, whereby we supply to interested papers, magazines and periodicals, articles thought to be of use in public health and preventive medicine. This has been warmly received and appreciated, especially by the country Press, and the work continues. You will all know about the B.M.A. spokesman and the excellent work he has done over the years. In addition to this, we have recently completed arrangement for 52 weekly programmes, sponsored by Australia's leading financial institution. We hope that, if this venture proves a success, the same firm may sponsor a television programme. Not that we have overlooked television hitherto; we have given this medium much thought. It is a tricky and extremely expensive publicity channel. A few pilot programmes have been attempted, but these have lapsed lately for lack of a sponsor. Recently we were approached about a programme that would have cost us £10,000 to produce. This, of course, is beyond our resources.

3. Between the doctor himself and his patient. This may well be the most important of all. It would be somewhat unnecessary on my part to remind doctors that by proper care of and compassion for the sick, combined with reasonable fees, a great goodwill can result. But I wanted more to say that, by doctors studying medico-political problems and then explaining them to their patients, incalculable good may result.

In these public relations efforts we have been advised by representatives of the world's leading firm in this field. They are on a part-time basis at present, but many responsible members of Council believe that this service

must be full-time. The cost, as you will see by the accounts, is only token at this stage. Indeed, by overseas standards it is quite negligible, if you remember that the Parent Body spends some £20,000 to £30,000 yearly on this activity, whilst the American Medical Association spends \$500,000 yearly for this purpose. They feel it to be a very worthwhile investment. We can do no less, proportionately.

#### National Health Service.

This country has embarked on a health service which, at its inception, promised a worthwhile compromise between the cherished doctor-patient relationship and the economic costing of drugs and services. The Act has many good features, but also many weaknesses and potential dangers for a free profession. There were many members of Council who voiced serious misgivings at the inception of negotiations with the Federal Government for a Pensioner Medical Service. The danger was seen of allowing too much of a doctor's income to come directly from the Government, and so, to that extent, to his becoming dependent on this source, with the control that is inevitable. These fears appear well grounded in the light of subsequent events. Of late years, when we have attempted to obtain higher fees for this service and an impasse seemed inevitable, we have asked members if they were willing to abandon the scheme in that event. They have always voted for continuation, showing a great degree of dependence on this source of income, which they feared to lose.

#### Welfare State.

We have been aware for some time that the shades of the Welfare State, like the shades of the prison-house in Wordsworth's ode, are beginning to close upon us, as upon the growing boy. In fact, we have been aware that these shades may well materialize into shackles for us, as has happened to our confrères overseas. So let us face the facts. The Welfare State, for good or ill, is already here. If we had any lingering doubts on this score, they were dispelled very bluntly recently by a senior member of Cabinet, who reminded us of this fact, and said there was little we could do about it. Governments of late years have given up the frontal type of attack on the profession in favour of infiltration. This can be very effectively carried on by the pernicious development of government by regulation. The *National Health Act* lends itself admirably to this method of attack. Dangerous regulations may be implemented this way.

The latest amendment in respect of extended pharmaceutical benefits was an example of breach of faith by the Government, in bringing these proposals forward without consulting the Federal Council, or allowing time for discussion and negotiation. Our request for time to do this was peremptorily refused. This Council has opposed these proposals from the first moment that they were hinted at. It has been practically a single-handed fight. Despite the strongest possible protest and cogent arguments, we were unable to induce the Federal Council to accept our views on non-acceptance. In its wisdom, Federal Council accepted them, and decided on a review in six months. We believe that this is a dangerous interval to allow go by. We have not given up the struggle, and the plebiscite in which you will by now have been asked to vote will determine our future course of action. Only by getting two other States to join us can we demand a special Federal Council meeting to review the profession's attitude.

It will be obvious, then, why I now appeal to all members to be more active in medical politics. It is important to attend regularly meetings of local associations. They are held infrequently enough to be no burden. In this way members will be well informed on important problems in hand. Also, delegates from local associations to quarterly meetings of Council should be more diligent in attending. Some have never attended a meeting, others have attended very infrequently. When it is remembered that many Councillors travel hundreds of miles, sometimes weekly, to attend meetings, and go from one end of the State to the other on Association business, it should not be asking too much for delegates to come in from the suburbs, at the

most four times a year, or even for the country delegates to attend.

#### Conclusion.

These remarks are mostly in a pessimistic, though realistic vein; but there is also a brighter side. The profession is very prosperous, I think it must be conceded. This very prosperity bears the seeds of its own destruction in indifference and apathy. But a new development in sight may provide the necessary stimulus to activity. For this is the year of decision for the Association in Australia. By unanimous decision and, happily, with the benediction of the Parent Body, it has been decided to launch the Australian Medical Association, or the Medical Association of Australia, according to which title may be chosen. Already a steering committee is at work drawing up a framework for a constitution. It will require much anxious thought, so that, whilst all that is good in the old Articles is retained, new ideas may be incorporated, to ensure efficient and democratic government of the profession in this country. Particularly must the question of the representation of the more populous States at the Federal level be strengthened. This State, with over 40% of the doctors in Australia, has four representatives on Federal Council, whilst the smallest State, with but one-twentieth of our numbers, has two. This imbalance must be redressed.

In conclusion, in thanking you for the honour that has been done me this evening, and for your attendance, I ask for your continued loyalty and confidence in your elected representatives. When they are assured of this, I can assure you they will not fail the best interests of our calling.

#### SEASONAL EPIDEMICS OF ENDEMIC GOITRE IN TASMANIA.

By H. B. GIBSON, M.B., B.S.,

School Medical Officer,

J. F. HOWELER, M.Sc.,

Nutritionist, Division of Public Health, Tasmania,

AND

F. W. CLEMENTS, M.D., D.T.M., D.P.H.,

Institute of Child Health,<sup>1</sup> University of Sydney.

In the spring of 1956, when the primary school at Margate, in southern Tasmania, was visited for its annual routine medical inspection, it was noticed that the incidence of goitre was unusually high. A check of records of individual children showed that in many the thyroid had increased from a small normal size to visible enlargement; this had occurred during the previous one or two years. When similar observations were made at the larger area schools at Snug and Woodbridge in the same district, a goitre survey of all children attending the three schools was carried out.

Briefly, the goitre story of Tasmania up to this date had been that in March, 1949, a survey by one of us (F.W.C.) proved endemic goitre to be prevalent in most parts of the State. A recommendation that tablets containing 10 mg. of potassium iodide be distributed weekly to all children was implemented, and a check survey was made five years later to assess the effectiveness of this form of goitre prophylaxis. The figures obtained in March, 1954, led to an hypothesis that, whereas a considerable amount of goitre in Tasmanian school children was due to iodine deficiency, there were some districts in which other aetiological factors were involved. It seemed that a food goitrogen might be responsible, and suggestions were advanced concerning its possible source and mode of action (Clements and Wishart, 1956; Clements, 1957).

In March, 1954, the incidence of endemic goitre in children attending the Snug and Woodbridge schools had

<sup>1</sup> Endowed by the Commonwealth Department of Health.



been 4.6% in the boys and 13.2% in the girls, a rate approximating the over-all incidence for the State. In November, 1956, 35% of the boys and 36% of the girls attending the three schools had visibly enlarged thyroid glands. At this time the incidence for the whole of southern Tasmania, calculated from school medical records, was about 7% in boys and 10.5% in girls.

It was decided to test the suggestion of Hercus that iodine, if given in sufficiently high dosage, would counter the effect of a food goitrogen (Hercus, 1953); this was done by increasing the prophylactic dose of potassium iodide to 10 mg. twice a week at Margate and Woodbridge schools, keeping the dose for the children at Snug at 10 mg. once a week as a control, and observing the effects in each group by routine surveys at half-yearly intervals over a number of years.

In the autumn of 1957 there was a sharp decline in incidence in all three schools, followed by another rise in the spring of that year. In 1958 there was again a seasonal variation, a decline in autumn followed by an increase in the spring. The surveys in 1958 were made at quarterly intervals, and it appeared that, while the peak occurred at Margate in September, the highest incidence was not reached in Snug and Woodbridge until December. Another decline, particularly apparent at Margate, occurred in March, 1959, which was continued in June.

The seasonal trends are shown in Figure I, from which it will be seen that there have been three substantial epidemics of endemic goitre which occurred at about the same time each year. The peak incidence appears to be in late spring and summer, and the troughs occur in the autumn and winter. It seems that the peaks do not occur at exactly the same time each year—a fact worthy of investigation.

#### Description of the Locality.

##### Geographic Considerations.

The area under investigation is the coastal littoral running to the foot of mountains which rise to 2700 feet; it extends from Kingston in the north to Gordon in the south, and six small towns and an equal number of hamlets lie in between (see Figure II). Approximately twenty rivulets run from the mountain slopes towards the D'Entrecasteaux Channel.

Geologically, this area can be described as an area occupied by Permian and Triassic flat-bedded sedimentary rocks, intruded by Jurassic dolerite and an alkaline suite of Tertiary rock.

##### Climate.

The average annual rainfall varies little from 25 in. in the area from Hobart to Kingston, but increases to about 35 in. at Woodbridge. It remains essentially constant along the coastal strip to Gordon. In the hills, the rainfall would be several inches higher, although no records exist to substantiate this; the annual rainfall there is probably in the vicinity of 40 in.

Frost occurs on about 150 days in the year, and the incidence increases with altitude. Light snowfalls may be expected on the hills, with snow settling about twice each winter. The average annual summer and winter temperatures vary slightly from 60° and 42° F. respectively along the coastal areas. The spring usually commences about September along this coastal strip. In 1958 it started much later in Woodbridge and the area further south.

##### Economic Considerations.

According to the census of June 30, 1954, approximately 5000 people live in this area. At the low-lying coastal strip, where most of them live, mixed farming, orcharding, fishing, dairying and grazing, and manufacturing are the main sources of income. Mining, quarrying and forestry take place in the foothills. In the valleys running inland different types of berry crops are grown. At Electrona there is a carbide-producing plant, and a small coalmine operates at Kaoota. In this area 512 families are engaged in agriculture and mixed farming, 300 in manufacturing,

135 in fishing, 84 in dairying and grazing, and 14 in mining, forestry and quarrying. A large number of local inhabitants are temporarily employed during the apple season, picking and packing, and also in the scallop season, cleaning and packing.

##### Sources of Food.

Although a considerable percentage of Tasmanians are employed in primary industries, a large number of food items are imported from other States; the transport costs make some foods expensive.

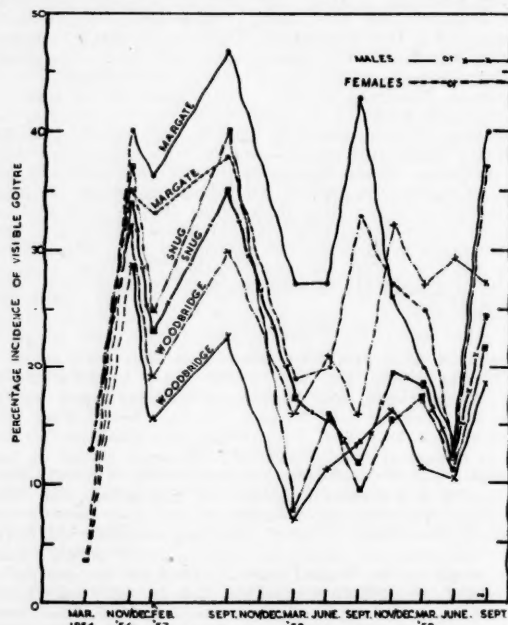


FIGURE I.  
Seasonal epidemics of endemic goitre in children attending three schools in southern Tasmania.

**Meat.**—Local slaughterhouses in each township supply the inhabitants. Of the stock, 75% comes from local pastures. However, when prices are favourable, stock may be obtained for other areas from the central plains of Tasmania.

**Fish.**—Although there are several fishermen in this area, little fresh fish is available for the population; such fish as is eaten is canned. At the beginning of the scallop season scallops are eaten several times a week by most families, but after a month the novelty wears off. For the rest of the year, if fish is eaten, it is usually canned.

**Eggs.**—Eggs are locally produced.

**Milk.**—There are three types of milk producers in this area, the dairy-farmer, the mixed farmer with several cows, and the private householder who keeps one "backyard" cow. Approximately 3500 gallons of milk are produced daily and transported to Hobart to the factories for processing; this amount is supplied by about 80 producers. Some producers may supply as little as five gallons daily. Spring surpluses are taken by the Hobart milk factories, but appreciable quantities are also sold to neighbours and friends of the producers. Reliable figures for this amount cannot, unfortunately, be obtained because the procedure is illegal.

The householders use three different types of milk—fresh local, pasteurized bottled, dried—or combinations of the three. Pasteurized milk is from the general pool at the Hobart factories and theoretically could come from



any part of Tasmania. Milk powder is imported from New South Wales and Victoria. Locally consumed fresh milk is produced under a number of different conditions. Some owners graze their cows on improved pastures and others on fallowed land growing a mixture of grasses and weeds, while others again tether the cow on the side of a quiet road. The composition of swards of these grazing areas seemed important, so in April, 1958, one of us (J.H.) made a survey of 62 pastures used for grazing milk cows

commonly found in the neglected pastures, old cultivated land, vacant building blocks and the roadside was as follows: docks (*Rumex* sp.), 26; dandelions (*Hypochaeris* sp.), 56; buttercup (*Ranunculus* sp.), 14; watercress (*Nasturtium officinale*) in the damp patches, bracken, blackberries, briars and thistles, 57. Small quantities of wild radish (*Raphanus raphanistrum*, 6) and wild turnip (*Brassica tournipartii*) were recorded in the Huon Valley, but no actual figures are available for the coastal area in which this epidemiological study was made. However, the two areas are considered to be quite different. During the studies here described, we noted many paddocks around homes, in which cows were grazing, heavily contaminated with wild turnips. They presented a strikingly picturesque appearance owing to the massed effect of the small whitish-purple and yellow flowers. In October, 1959, even more paddocks in this area were found with this contamination, and cows were seen eating the plant, flower and all.

Pasteurized milk (one-third of a pint) is supplied free to school children, at school. This is drawn from the pool of milk in Hobart, which is built up from milk produced in all parts of Tasmania, although southern suppliers contribute the larger amount.

**Butter.**—Most of the butter used is produced in Tasmania's north-west. A small amount of butter is produced locally in the area surveyed, but at some season of the year taints occur. This may be due to flush conditions at springtime, when clover is dominant in many pastures, or when, during periods of feed shortage, cows eat buttercups.

**Cheese.**—People in this area eat very little cheese, although Victorian cheese is available in the shops. Cheese is not manufactured locally.

**Wheat, Bread, Flour.**—Most breakfast cereals are imported from Victoria and New South Wales. Bread is baked from imported wheat, mostly from South Australia and Victoria. Flour obtained from Tasmanian wheat is used for biscuit manufacture.

**Vegetables.**—Many families reported that their vegetables were home grown or bought from an itinerant vegetable truck, which obtained its supplies from wholesale merchants in Hobart. Wholesale merchants buy root vegetables from other parts of Tasmania—for example, the north-west and the Scottsdale area in the north-east. Other vegetables, such as lettuces, etc., are grown around Hobart. Some peas, celery and tomatoes are imported from the mainland.

**Fruit.**—Apples, pears and berry fruits are available in large quantities, as they are grown locally. A few apple-packing sheds have installed cool stores; this means that some families can eat apples and pears all the year round. However, most people in the Channel district find it difficult to buy fresh fruit that is out of season. Citrus fruits are seldom eaten because of the cost, being imported from the mainland.

**Summary.**—Meat, fresh milk and some vegetables and fruits are produced in the district, and so could be affected by local conditions. Bread, breakfast cereals, pasteurized and dried milk, most of the potatoes and root crops are produced either in other parts of Tasmania or on the mainland, and so would not be affected by the local conditions.

#### The Incidence of Various Types of Thyroid Enlargement.

A continuous record of the size of the thyroid has been kept for 403 children at the three schools for the three years 1957 to 1959. These results are summarized in Tables I and II.

The noteworthy points in the two sets of results are the similarity in the figures for the two sexes, and the almost identical incidence of seasonal variation. The children recorded as having a variable enlargement showed a number of changes in size, but without a distinct seasonal incidence. The seasonal variation was most marked in children aged seven to ten years. The number

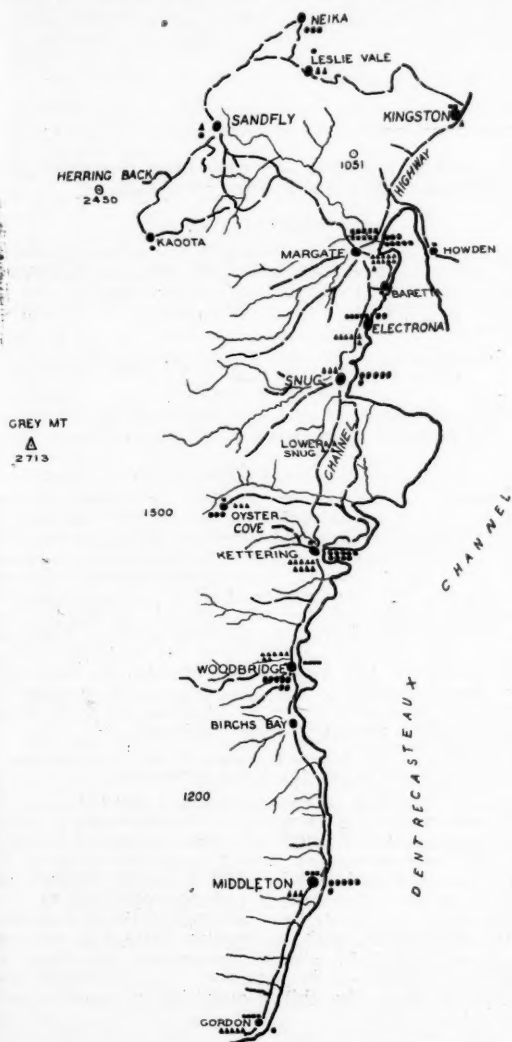


FIGURE II.

Map of the D'Entrecasteaux Channel, southern Tasmania, showing residence of children marked according to the status of the thyroid gland. Circles, no goitre; squares, persistent goitre; triangles, seasonal goitre.

in the adjoining Huon district, to determine the extent to which they were contaminated with cruciferous weeds. A variety of conditions were recorded.

Most farmers with several cows had well-developed pastures, planted with subterranean, white or red clover and Italian or English rye-grass, or meadows with a thick sward of indigenous grasses. Land that had recently been used to grow a crop often had a heavy infestation with weeds. Some pastures were neglected and showed extensive weed growth. The ratio of the weeds most

TABLE I.  
Incidence of Various Patterns of Thyroid Size over Three Years by Year of Birth of Children: Boys.

Year of Birth.	No Goitre.	Seasonal Enlargement.	Constant Enlargement.	Variable.	Decrease in Size.	Increase in Size.	Total.
1944 ..	6	1	2	—	1	—	10
1945 ..	4	2	7	2	3	—	18
1946 ..	6	6	5	4	6	3	30
1947 ..	5	14	12	3	1	—	36
1948 ..	7	12	8	3	3	2	35
1949 ..	7	16	12	3	2	1	41
1950 ..	2	9	14	6	—	—	31
1951 ..	4	7	5	2	—	3	21
Total	41	67	65	23	16	9	222

of records of children aged less than seven years were too few for comment; above the age of ten years, a progressively smaller percentage of children showed a seasonal enlargement, and in the majority of children so affected the increase in thyroid size was not so great as at the younger ages.

#### Relationship of Thyroid Size to Environmental Factors.

Groups of children with no thyroid enlargement, a seasonal enlargement and a constantly enlarged thyroid were investigated in detail through interviews with the parents, usually in their own homes. The purpose of this part of the inquiry was to determine whether there were differences in the three groups in respect of the following features.

##### Residential Area.

The place of residence of each child is shown on the map (Figure II). The numbers are too small for any conclusions to be drawn, except that there does not appear to be a significant concentration of children with any particular type of thyroid in any locality.

##### Duration of Residency in the District.

Ten years' residence in the area, or life for those aged less than 10 years, was taken as the criterion for comparison; 56% of children with a seasonal variation, 66% with a constant goitre and 62.5% without thyroid enlargement fulfilled this condition, no significant difference being found.

##### Standard of Living.

The standard of living found in the three groups of children varied widely within each group, there being little difference between the three groups. Some homes were decidedly unsatisfactory and primitive, while at the other end of the scale there were well-kept homes with the most modern labour-saving devices. The standard of mothercraft also varied over a wide range. Some mothers worked throughout the apple and scallop seasons during the week and week-ends, often leaving the children to do the housekeeping and cooking; some mothers would take the children with them while working; many other mothers stayed at home. In all three groups these

differences in maternal care were found and there were no significant differences between the groups.

##### Water Supply.

The water supply of the three different groups of children was similar; more than 50% used rain water, approximately one-third used municipal water supplies, and the others had combinations of tank, reservoir and stream water.

##### Relationship of Thyroid Size to Personal Factors.

##### Occupation of Father.

There appears to be no correlation between the type of thyroid size and the occupation of the parents.

##### Stress in the Child's Life.

Excessive stress, either physical or emotional, may possibly throw undue strain on the thyroid; in children with a borderline supply of iodine or borderline output of thyroxine due to derangements of metabolism in the gland, the stress may lead to thyroid enlargement. It was decided that the team could not collect information about emotional stress and the child's ability to handle it, so the inquiry was limited to physical stress. Prolonged illness and physical fatigue due to excessive manual activity before and after school and at the week-ends, and from travelling to and from school, are probably the two most important forms of physical stress to which school-children are likely to be subjected.

A review of the illness patterns of the three groups of children did not show significant differences.

Activity is extremely hard to measure, and it is conceded that some activity is essential for the satisfactory growth and development of children. The significant factor is probably the atmosphere in which the activity is undertaken. Games and activity with a strong pleasure and self-satisfaction element are probably different, in their effects upon the child, from activity which is associated with enforcement, such as regular daily and week-end farm or household chores, particularly if these are sufficiently heavy to be fatiguing. The mothers were questioned about the child's activities in these contexts,

TABLE II.  
Incidence of Various Patterns of Thyroid Size over Three Calendar Years by Year of Birth of Children: Girls.

Year of Birth.	No Goitre.	Seasonal Enlargement.	Constant Enlargement.	Variable.	Decrease in Size.	Increase in Size.	Total.
1944 ..	6	2	3	4	—	—	15
1945 ..	3	3	3	2	2	2	15
1946 ..	4	3	5	5	3	1	26
1947 ..	5	6	7	3	1	—	18
1948 ..	10	13	3	2	—	—	32
1949 ..	6	9	5	2	2	2	26
1950 ..	7	9	8	6	—	1	31
1951 ..	5	5	6	—	1	1	18
Total	46	55	40	24	9	7	181

and each child was rated on a scale which extended from minimal routine enforced activity to heavy fatiguing chores. No differences were found in the percentages of children in each category in three groups of children arranged according to thyroid enlargement.

Similarly, no differences were found in the amount of energy spent getting to and from school in three groups of children arranged according to thyroid enlargement.

Thus, illness, activity and energy spent on travelling to and from school do not seem to correlate with thyroid enlargement.

#### Diet.

Information was also obtained concerning the usual diet of the children, and specific likes and dislikes of foods were recorded.

The meal pattern followed the customary Australian plan of three main meals with two small in-between snacks.

1. Breakfast. The breakfasts of 108 out of the 135 children under investigation consisted of processed cold breakfast cereals with a small amount of milk, and/or toast with tea or milk. As this survey was conducted during April, it may be expected that more children would have a cooked breakfast during the winter months. From the nutritional point of view these breakfasts were not satisfactory, because they were deficient in protein and calories.

2. Lunch. As many children have to travel from outlying districts, and because so many mothers are working in the small-fruit and apple industries, it is not surprising that 125 out of the 135 children had sandwiches for lunch. Frequently these sandwich meals were augmented with cake and cordial.

3. Dinner. The usual pattern for the last meal of the day was meat, potatoes, two types of vegetable and a dessert. In-between meals consisted mainly of school milk, biscuits, cake and apples.

No difference could be found in the meal-pattern of the three groups of children, or in the qualitative evaluation of the nutritive value of the diets.

#### Milk Intake.

A special effort was made to estimate the quantity of milk consumed by the children, as a beverage and in cooked food. The most common level of intake was from one-half to one pint per day consumed by about half the children, with almost identical percentages in each of the three main groups arranged according to thyroid enlargement. Another 25% took less than half a pint per day, and the distribution was again similar in the three groups. The obvious conclusion is that the actual quantities of milk consumed by the children in each group were not significantly different.

The hypothesis advanced to explain the continued occurrence of endemic goitre, despite the high regular prophylactic intake of iodine, is that the milk contains a goitrogen derived from the food or the pastures on which the cows graze. This is more likely to be present in a higher concentration in locally produced fresh milk than in the pooled pasteurized milk. For this reason the sources of milk for each household were noted, and it was found that in about 70% of households some fresh milk was regularly taken and consumed by the children. There did not appear to be any differences in sources of milk between the children with a seasonal enlargement, those with a constant enlargement and those with no goitre.

#### Discussion.

The children studied over the three-year period can be divided into a number of categories, according to the behaviour of the thyroid gland. The thyroid of the majority, strangely enough almost 78% of both boys and girls, has presented a constant picture during the investigation, being normal in size (18% of boys and 25% of girls), constantly enlarged (29% of boys and 22% of girls), or subject to seasonal enlargement, with a significant increase in size in the spring and summer and a recession in the

winter (30% of both boys and girls). The remainder of the glands were variable, decreased or increased in size.

Perhaps the most noteworthy feature of these observations is the consistency of behaviour of the thyroid gland in the majority, and coupled with this, the regular enlargement in the same children each year.

The duplication of the pattern in both sexes, especially the similarity in the percentages affected, calls for comment. Most reports on the incidence of endemic goitre in areas where the indications are that the condition is due to iodine deficiency have revealed a significantly higher incidence of enlargement in girls than in boys; the ratio varies from about 2:1 to 4:1, the higher ratios occurring in older children (Clements, 1958).

The peak in the incidence of seasonal enlargement, occurring as it does in children aged from seven to ten years, may be a significant feature of this inquiry. The similarity of the curves for the children at the three schools, despite the difference in the size of the prophylactic dose of iodine, indicates that iodine deficiency is not the cause of the seasonal enlargement in those so affected. In those children in whom the seasonal increment occurs on an already enlarged thyroid, the possibility exists that iodine deficiency may be the cause of the basic enlargement. This can be discounted in those children in whom the seasonal increment occurs in a gland which is normal in size in the winter. It is also important to point out that, despite three years of intense, carefully supervised prophylaxis with doses of 10 and 20 mg. of potassium iodide per week, young children are still developing an enlargement of the thyroid gland while under the surveillance of the school medical officers.

The epidemiological study of the three main groups of children—those without thyroid enlargement, those with a seasonal enlargement and those with a constant enlargement—failed to reveal any differences between the three groups in respect of physical living environment, living conditions, way of life, water supply, dietary patterns or sources of milk consumed in the family. Laboratory studies, made some years ago, demonstrated the presence of a goitrogen in milk collected from cows in Tasmania fed on *chou moellier*, and also in milk from cows in southern Queensland grazing on pastures heavily contaminated with Queensland wild turnip (*Rapistrum rugosum*) (Clements and Wishart, 1956).

An examination of the thioglucosides and their aglucones occurring in weeds contaminating pastures in goitrous areas of Tasmania and Queensland is proceeding at the School of Biochemistry, University of Melbourne;  $\gamma$  methylsulphonyl propyl-isothiocyanate has been isolated from the fruit and leaves of the Queensland wild turnip weed (*Rapistrum rugosum*) and shown to reduce the uptake of  $I^{131}$  by the thyroid gland of the rat (dose 5 mg.). The yield of pure aglucone (1.2 grammes per kilogram of dry fruit and 0.4 gramme per kilogram of fresh leaves) would indicate a potentially high consumption of the substance by a grazing cow during a twenty-four hour period, since many pastures in southern Queensland are heavily infested with this weed (Bachelard and Trikojus, 1959).

Attention has been drawn to the heavy contamination with Tasmanian wild radish and wild turnip of some domestic grazing paddocks in the area of southern Tasmania covered by the present survey. Work has not yet been undertaken on Tasmanian plants, other than *chou moellier*, to determine the presence of a goitrogen. However, the timing of the peaks of incidence suggests that a pasture factor is involved.

The seasonal epidemics of endemic goitre coincide with the spring flush of pastures and weeds, and it is interesting to note that in 1958 the peak of the increase in size was delayed in the children attending Woodbridge school until December, whereas in other years in the three schools, and in the two more northern schools (Snag and Margate) in 1958, the peak had occurred in September, which was the time of the peak in the three schools in previous years. The delayed peak coincided with the delayed arrival of spring at Woodbridge and with the growth of weeds in



the pastures. The commonest of these, including the wild radish and wild turnip, undoubtedly require investigation in the same manner as the Queensland wild turnip has been studied.

It is worth recording that children with a normal thyroid, seasonal enlargement and constant enlargement were found in the same family. So far as could be determined, the way of life and dietary patterns of those children were similar. The amount of milk consumed by the various children in each of these families was not markedly different, and in every family the milk was obtained from a common source—their own cow, a neighbour's cow or the distributors of pasteurized milk. It should also be noted that children consume varying amounts of milk at school, which is pasteurized and comes from the "pool" in Hobart.

These findings suggest that, while it seems probable that a naturally occurring goitrogen or goitrogens, obtained through milk, are the ultimate causal factor in the seasonal increments in thyroid size, it is clear that these substances do not affect all children in the same way. There appears to be some personal idiosyncrasy in those children affected which, so far as we have been able to determine, does not arise from the child's physical, social or emotional environment. We are left with the proposition that something inherent in the child makes it behave in the way it does to a regular dose of a goitrogen.

The figure of 30% of children with seasonal variation reminded us that approximately 30% of people of Caucasian stock cannot taste as bitter phenyl thiourea (PTC) (Harris and Kalmus, 1949) and other goitrogen compounds like 2-mercapto-5-5-dimethyl oxazoline (Hopkins, 1938). It is generally believed that the non-taste characteristic is a recessive gene (Boyd, 1950). The possibility that children with a seasonal variation could not taste PTC was tested. The results are to be published (Howeler, Gibson, Clements, 1960); suffice it to report here that no correlation was found. This does not, of course, exclude the possibility that susceptibility to a food goitrogen is an inherited characteristic.

#### Summary.

1. Details are given of annual epidemics of endemic goitre over a three-year period in school-children in three southern Tasmanian schools. The peaks of the epidemics occur in the late spring and early summer, with a recession in the winter. All children had received prophylactic doses of potassium iodide regularly.

2. The same children appear to be affected each year, and they constitute some 30% of the children studied. In addition, it was noted that approximately 18% of boys and 25% of girls had a normal thyroid over the period of the study, and 29% of boys and 22% of girls had a constantly enlarged thyroid.

3. In an epidemiological study no differences were found in the physical environment, economic status, way of life, dietary pattern or milk consumption of the children in each of the groups.

4. The seasonal increase in size appears to coincide with the spring flush of pastures and weeds. The possibility is discussed that a food goitrogen present in the milk and originating in weeds or fodder may be responsible for the seasonal increment.

5. The possibility that susceptibility to a food goitrogen is an inherent characteristic of the children affected is considered.

#### Acknowledgements.

We desire to place on record our indebtedness to the headmasters and teachers of the three schools where these studies are being conducted, without whose cooperation this work would not have been possible. We also wish to thank school nurses, who have supervised the regular distribution of tablets of potassium iodide, and who also participated in collecting some of the data incorporated in this communication.

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### MANAGEMENT OF HAND INJURIES IN GROUP PRACTICE.

By GORDON TRINCA, M.B., B.S.,  
Melbourne.

INJURIES to the hand are constantly encountered in general practice. The source of these injuries is domestic and industrial, the proportion depending on the situation of the medical practice and to a lesser extent on the facilities provided by that practice. The purpose of this article is to show that these injuries can be efficiently and promptly treated without disturbing the normal running of a busy practice. This applies particularly in a group practice, where at all times one or more doctors are in attendance. The difficulties occurring in a one-man practice are obvious, and it is not proposed to elaborate on these.

The integrity of the human hand is vital to the security of all involved in active daily work. Injuries to the hand, however trivial, must be given the attention that is their due. Too often a cut finger or hand is considered a nuisance and is hastily sutured; nor is much consideration given to after-treatment and rehabilitation.

It is proposed to show that, by providing adequate facilities and adopting an organized procedure of treatment, primary healing can be obtained in practically all cases, and complications and disability reduced to a minimum. The ability to obtain this objective is of particular importance in industrial cases.

This article does not intend to encourage general practitioners to invade the province of the specialist. Rather is it a plea for a considered and sympathetic approach to these injuries and an awareness of the structures that can be damaged, plus early recognition of the more serious injuries. All too frequently the plastic surgeon is called in too late, to treat not mismanaged injuries, but injuries that were initially overlooked. B. K. Rank and A. R. Wakefield (1953) have clearly demonstrated the problems to be encountered in the management of hand injuries, and it is strongly recommended that every general practitioner should study the advice of these authors. Then he will be in a better position to judge which injuries he can treat himself and which patients should be referred to someone more experienced in the management of these injuries.

#### Adequate Facilities and Materials.

##### Operating Theatre.

A group practice should have a room set up as a minor casualty theatre. There should be a minimum of furniture and movable equipment to avoid dust traps. Linoleum or

rubber forms a satisfactory floor covering. Only materials, lotions and instruments in use should be kept in the theatre, bulk materials being stored elsewhere. Wide shelves at workable height can be attached to the walls, and these may be surmounted by shallow, open compartments containing lotions, materials, etc. "Laminex" and "Vitrolite" are excellent coverings for the wide shelves or benches. A well-fitted stainless-steel sink with double-action taps is essential for "scrubbing up". A necessary requisite is an electric sterilizer.

#### Trained Staff.

A trained sister with theatre experience is a great asset. One trained in the principles of asepsis, the care of instruments, the preparation of suture trays and the nature of lotions and dressings assists materially in obtaining good results and prevents irritating delays and errors.

#### Dressing Annex.

An annex adjacent to the theatre facilitates the treatment of injuries. This room may be subdivided into dressing and waiting sections. By this means a rapid turnover of patients can be effected. Post-operative dressings and review of patients are carried out in the treatment section, whilst the waiting section serves to separate the patients with injuries from the usual habitués of the general waiting-room.

#### Materials and Instruments.

Sterilized stock—for example, gauze, cotton-wool and towels—should be available. Any nearby hospital will willingly autoclave materials, and a small autoclave bin is useful for this purpose. Good results in suture repair cannot be obtained with coarse instruments or suture materials. The list of instruments recommended by Rank and Wakefield forms one of the essential requirements for good repair. The hand-stand used by these authors is more than useful.

#### Portable X-Ray Machine.

A portable X-ray machine, the use of which is confined to extremities, is within the scope of general practice and is an essential part of the equipment for dealing with hand injuries. Radiological evidence of the site and extent of fractures as well as of the presence of opaque foreign bodies is frequently required in these injuries. The delay in developing films is short, and often radiological assessment is necessary before operative repair can be attempted.

#### Prevention of Infection.

The asepsis obtained in a major operating theatre of a public hospital is neither possible nor practicable in an average group practice. The following desiderata should not be difficult to follow: (a) thorough scrubbing of hands with soap and warm running water (the use of gloves is not necessary); (b) the wearing of a mask; (c) properly sterilized instruments, towels, gauze and dressings; (d) no "dirty" cases to precede the repair of clean injuries (opening of an abscess, etc., can be delayed or preferably carried out in another room).

#### Recommended Procedure in Treatment of Hand Injuries.

The following procedure has been adopted in a series of 220 consecutive cases. The routine is not time-consuming, and it is believed that it permits early recognition of the injury sustained and enables the correct treatment to be carried out at the earliest possible moment.

A special card has been devised (see below) on which all details are entered. On one side are recorded the cause of injury, the site and nature of the injury, pre-operative assessment, radiological investigation and operative assessment. On the reverse side are recorded the treatment and follow-up findings. The final result, including time away from work (if any), completes the record.

#### SIDE I.

Name. Age. Sex. Date.  
Occupation.  
Employer.  
Cause of Accident.  
Machine or Instrument.

#### Injury.

##### Pre-Operative Assessment.

General description.  
Clean or dirty.  
Tidy or untidy.  
Digit involved.  
Palm or dorsum involved.

Tendon function.  
Nerve function.

##### Operative assessment.

Tendon. Bone.  
Nerve. Soft tissue.  
Vascular. Nail.

##### Radiological assessment.

Bone.  
Opaque foreign body.

#### SIDE II.

##### Final Description of Injury.

##### Treatment.

##### Immediate.

1. First Aid. At place of employment.  
At clinic.
2. Preventive. A.T.S. or toxoid.  
Penicillin.
3. Operative. Anaesthetic.  
Specific details.

##### Intermediate.

##### Remote.

##### Final result.

##### Date of return to work.

Injuries have been divided into the following six broad categories: (a) lacerations, (b) crush injuries, (c) avulsion injuries, (d) guillotine injuries, (e) puncture wounds, (f) burns.

#### Initial Assessment.

In the initial assessment the type of wound is determined and assessed as dirty or clean. The presence of nerve, tendon or vascular injury is sought. Awareness of the possibility of tendon and nerve injury will prevent the unfortunate failure to diagnose these injuries. During this assessment a decision to examine the hand radiologically is made, in order to confirm and indicate the nature of bone involvement and the presence or absence of an opaque foreign body.

Patients with more severe injuries requiring extensive repair are referred to hospital for subsequent treatment. Initially in this series, patients requiring bone resection and extensive repair were treated in the operating theatre at the clinic. However, it was considered that these patients required the benefit of the aseptic conditions provided by a well-equipped hospital theatre. The time factor in a long case tended to cause bottlenecks. The occurrence of infection was not a factor in this decision, as there were no cases of infection complicating those severe injuries treated originally at the clinic.

After the necessary first aid, control of haemorrhage, relief of pain and covering of the wound with a sterile, dry, gauze dressing, the initial assessment as described above determines the course of action, as follows:

- (a) Refer to specialist;
- (b) Treat at clinic.  
Treat at hospital.
- (c) Form of treatment. Suture only.  
Bone resection.  
Nerve or tendon suture.  
Skin graft.

#### Preliminary Treatment.

All wounds of mild or moderate degree—and these formed the majority in this series—are soaked for 4 or 5 minutes in 1% "Cetavlon" solution. During this period

the setting up of the instrument tray is completed, X-ray examination is arranged and tetanus antiserum or toxoid is given.

#### *Tetanus Antiserum and Tetanus Toxoid.*

For all wounds tetanus prophylaxis is carried out. When there is complete certainty that the patient has been previously immunized with toxoid, 1 ml. of formalinized toxoid is administered subcutaneously.

If there is any doubt, 1500 units of tetanus antiserum are given after a previous skin test. Early in the series an intradermal skin test with 1 min. was made, but as the efficacy of this test is now seriously questioned, the intradermal test has been replaced by a subcutaneous injection of 0.5 ml. of 1:50 strength. Although there were no cases of acute anaphylaxis with tetanus antiserum, an appreciable number of local reactions and a few cases of moderately severe serum sickness occurred. The majority of these reactions occurred seven to 10 days after the original injection. An endeavour has been made to encourage all patients to complete tetanus immunization with toxoid (A.P.A.). Some success has been achieved in domestic cases, but industrial cases have been difficult to follow up. An attempt to induce local firms to immunize their employees has been singularly unsuccessful, an attitude which is hard to understand.

#### *Operative Procedures.*

**General Toilet.**—Gloves have not been used. It is held that the maintenance of a supply of autoclaved gloves is impracticable, and the policy has been to scrub up with soap and water for four or five minutes. A laundry-clean short-sleeved gown and a mask are worn. There is no evidence that infection has occurred with this procedure.

All wounds receive a thorough toilet. The lotions in use are "Cetavlon", "Zephiran" and "Hibitane". "Hibitane" has been used in preference to "Zephiran" in the latter part of the series. This also applies to the storage of instruments. It was found that there was far less tendency for instruments to rust in "Hibitane" than in "Zephiran". Normal saline is used freely in the cleansing and irrigation of wounds.

**Local Anaesthesia.**—Plain "Xylocaine" (1% solution) has been the local anesthetic of choice in all cases. In lacerations it has been found that slow irrigation of the wound with a few drops and then infiltration of the wound edges provide adequate anaesthesia. There is no evidence that this procedure has interfered with primary wound healing. This method, if carried out with patience, is very useful with children.

For more severe injuries of the fingers, anaesthesia is obtained by digital nerve block at the finger base. Blocking of the digital nerves at the base of the finger produces effective anaesthesia, and no complications will occur if the following criteria are adhered to: (a) plain "Xylocaine" (1% solution) must be used, and no more than 2 ml. should be injected per finger; in most cases 1.5 ml. will be sufficient. (b) Finger block must not be used in the presence of infection. (c) Digital block at finger-base level must not be used in cases in which viability is in doubt.

The following method of nerve block has been carried out in all indicated cases:

A "Sterling" syringe is used with a "Xylocaine" cartridge; a 2 ml. "Record" syringe serves the purpose equally well. A subcutaneous bleb is raised on the dorsum of the finger, and the needle is passed to each lateral border, the injection being given slowly. The needle is then withdrawn, and on each side it is passed forwards parallel to the bone until the point is felt just deep to the skin on the volar surface. The needle is slowly withdrawn while the anaesthetic agent is injected. Without being completely withdrawn on the dorsal surface, the needle is now directed diagonally forwards and inwards until the point strikes bone. Injecting anaesthetic solution, the needle is passed forwards close to the bone until the point is level with the anterior surface of the bone. The needle is then withdrawn and the procedure is repeated on the other side.

The use of a rubber band or fine rubber tubing as a tourniquet around the base of the finger combined with this method of finger block has not resulted in vascular spasm or permanent impairment of circulation. The more painful methods of infiltration of the digital nerves by the palmar or dorsal routes can thus be avoided.

**Operative Assessment and Treatment.**—A further assessment of the injury is made when the wound is anaesthetized. It is not uncommon to find a severed tendon with a relatively minor laceration. The wound should be thoroughly inspected for deeper injury and for soiled and damaged tissue. All wounds are debrided and well irrigated with saline. It is in the repair of these wounds that the proper fine instruments are so essential. In all cases it has been the policy to preserve the maximum of viable healthy tissue. Careful attention has been given to the approximation of wound edges and the choice of fine suture materials and needles. Fine nylon has been used in all cases of skin closure.

**Antibiotic Powders.**—Initially penicillin-sulphanilamide powder was used, but this was abandoned as bad in principle, and any badly contaminated or contused wound is "covered" by penicillin given intramuscularly. Because of the increasing frequency of penicillin sensitivity, inquiry to this effect is made before penicillin is administered. In deep and extensive wounds a dusting with neomycin powder—for example, "Spersin"—is given. The efficacy or otherwise of this powder has not been definitely determined.

**Dressings.**—Wounds have been covered with dry gauze or *tulle gras* and gauze. A single layer of *tulle gras* has been used on any wound with skin loss, on ragged lacerations and on skin grafts. Apart from these types of wounds, and particularly with tidy lacerations, it appears immaterial whether the wound is covered with *tulle gras* or dry gauze. Acriflavine emulsion and "Nitrofurazone" ointment have been used in a number of cases; but these substances seem to have no advantage over *tulle gras*.

Most wounds have been bound initially with a crêpe bandage, care being taken to avoid excessive bulk and tightness. For subsequent dressings a tube gauze bandage replaces the crêpe bandage in most instances. The question of immobilization is undecided. A wooden or plaster splint provides complete rest, encourages healing and reduces pain. However, it is realized that prolonged splinting can result in serious and sometimes permanent stiffness of finger joints. It has been the practice to use bandaging alone for lacerations, and plaster immobilization for more extensive soft-tissue injury or when more complete immobilization is necessary—for example, in tendon suture, skin grafting and compound fractures. When skin grafting is required, plaster splinting has not been found necessary if the area to be grafted is small and is not influenced by joint movement. When splinting has been necessary, the aim has been to immobilize the fingers with the joints slightly flexed.

#### *Follow-Up Investigation.*

All patients with severe injuries are examined again in 24 hours; but dressings are not disturbed unless there are indications—for example, excessive pain or bleeding. It has been the policy in cases of simple laceration to inspect and redress the wound in two or three days. An attempt was made at first to leave the dressings intact until the time of removal of the sutures; but it was found that patients were unable to keep their hands dry and that within 48 hours most dressings were soiled and moist. It was therefore decided to dress all these wounds every second day until the sutures were removed. At the time of dressing the wounds were lightly dabbed with spirit and a dry gauze dressing was applied. The method of follow-up investigation of the more severe injuries will be discussed in the appropriate sections which follow.

#### *Rehabilitation.*

Throughout treatment it has been found that the patient responds well to encouragement and personal interest on



the part of the doctor attending him. The doctor who initially treated the patient should carry out the after-treatment until the patient is discharged. The importance of early finger and joint movements cannot be too strongly stressed, and the aid of a physiotherapist should be enlisted when this is indicated.

Full restoration of function is the only successful result. A mobile active hand with partial loss of digits is better than a stiff wasted hand with all digits intact.

#### Discussion of Injuries and Further Procedures.

This series comprised 220 cases, of which 181 (82.3%) were industrial and 39 (17.7%) were domestic injuries (Table I). All but six of the domestic injuries were lacerations.

TABLE I.  
Type and Location of Injuries.

Type of Injury.	Number of Cases.	Location of Injury.	Number of Cases.
Laceration .. ..	122 (55.4%)	Finger(s) .. ..	131 (59.5%)
Crushing .. ..	34 (15.5%)	Thumb .. ..	38 (17.3%)
Avulsion .. ..	27 (12.3%)	Palm or dorsum ..	46 (20.9%)
Puncture .. ..	18 (8.2%)	Combined .. ..	5 (2.3%)
Guillotine .. ..	10 (4.5%)		
Burn .. ..	9 (4.1%)		

**Lacerations.**—Simple lacerations accounted for 103 cases, and in the remaining 19 there was involvement of bone, tendon or nerve.

Uncomplicated lacerations were made up of 76 industrial cases and 27 domestic cases. There was no loss of time from work in 37 of the industrial cases, and the average time loss in the remaining 39 cases was 7.8 days. Loss of time from work was determined by the severity of the injury and the nature of the employment. In the latter part of the series patients were encouraged to continue their occupation, and this did not result in infection or delay in healing.

Complicated lacerations form a very important part of this series, as it is in these cases that deeper and more serious injury to underlying structures may be overlooked if the wound is not thoroughly examined before suture. Of these complicated lacerations, 13 were industrial and six domestic. The nature of the deep injury was as follows: tendon injury, 10 cases; bone injury, four cases; bone and tendon injury, 3 cases; digital nerve injury, 2 cases.

**Crush Injuries.**—Severe crush injuries with bone involvement have been treated in hospital. Earlier in the series such injuries were treated in the theatre at the practice, but this procedure was abandoned for two reasons. First, it was held that these injuries warranted full hospital and operating theatre facilities. Second, the length of time taken for the repair tended to cause bottlenecks. Such injuries as were treated at the practice were not complicated by infection or delayed healing.

Resection of bone was determined by the ability to obtain skin or soft-tissue cover. The minimum amount was resected in order to obtain a functioning digit. Exposed digital nerves were cut well back to avoid neuroma formation. Full penicillin cover was given, and immobilization was obtained with a plaster splint.

The 34 cases of crush injury were made up as follows: There were 16 cases of compound fracture; seven patients required *débridement* and suture, five required resection of bone and formation of a volar flap, three required dressing only, and one required reduction of the fracture and suture of a severed extensor tendon. Of the 10 patients with soft-tissue disruption, seven required suture and three required dressing only. There were three cases of subungual haematoma. These patients had associated break in the skin, but no underlying fracture. The haematoma was released by either drilling the nail or incising

the skin just proximal to the base of the nail. In the two cases of contusion the contusion was severe, but there was no major skin disruption. In the three cases of mallet finger, no attempt was made at operative repair. The finger was immobilized in plaster with the distal interphalangeal joint hyperextended and the proximal joint flexed. Of the two cases in which a fragment of bone was avulsed with the tendon, a good result was obtained in one case. In the case in which no fragment was avulsed, the patient did not complete his treatment.

**Avulsion Injuries.**—There were 27 avulsion injuries, and 19 of these patients received skin graft. In seven cases pinch grafts were employed, and all but one took successfully. There was a 40% take in this case.

There were six cases of split skin graft, five of which were successful.

In the case that failed, the patient was referred to me two days after injury as a suitable subject for skin graft. She had sustained an avulsion injury of her index pulp, and a split skin graft was applied. Five days later the dressing was taken down because of pain and purulent discharge. An X-ray examination revealed a comminuted fracture of the distal end of the distal phalanx, and it was obvious that the graft had been applied to exposed bone fragments, although this had not been detected at the time of grafting. The wound was allowed to heal by second intention, and there was no final loss of function.

In five cases, avulsed flaps (non-viable) were sutured back into position. To obtain a successful take, it is essential to clean these flaps of all subcutaneous fat. This was done in these cases, and all flaps took successfully.

In one case a deep avulsion of the index pulp was treated with a cross-finger flap graft with pinch graft to the donor site on the dorsum of the adjoining finger. It is realized that a split-skin graft would have been preferable for coverage of the donor site. The final result in this case was satisfactory, and the pulp defect was well filled. However, it is believed that patients with such injuries should be referred to a plastic surgeon, as they require the attention of one who is constantly repairing these injuries. This does not apply in general practice.

Eight patients did not undergo skin grafting. In five cases there was only superficial skin loss, and these injuries were dressed with either acriflavine emulsion or *tulle gras*. All healed rapidly without infection. One patient refused skin grafting, one failed to return for further treatment, and the final patient was treated by undercutting the skin edges and suture.

Details of skin grafting procedure in all cases will be discussed in the appropriate section below.

**Puncture Wounds.**—There were 18 puncture wounds in this series, of which four were infected when the patients were first examined. The remaining 14 wounds were "clean", and the patients were examined within 24 hours of receipt of the injury, with the exception of one patient who presented five days after injury with a piece of glass in his palm.

Of the four patients with wounds already infected, two required incision and drainage of pus and one required incision and removal of a foreign body (wood). All four patients received antibiotic and anti-tetanus cover.

Of the "clean" wounds there were five with a foreign body *in situ*. Three of these foreign bodies were opaque, and their presence and position were confirmed radiologically before an attempt was made at removal. All 14 patients received antibiotic and anti-tetanus cover, and there were no cases complicated by infection. In two cases in which there was no foreign body, the puncture wound was opened up and explored and any stained tissue was excised.

**Guillotine Injuries.**—There were 10 guillotine injuries, three of which involved soft tissue only, and seven of which involved bone. In those involving soft tissue only, grafting was refused in one case and the wound healed

by second intention. Of the other two, a split-skin graft was applied to one and the other healed without skin grafting. The grafted wound failed because of haematoma formation under the graft.

Those injuries in which there was bone involvement were treated by resection of bone and the fashioning of a volar skin flap. In one of these cases, in which three fingers were involved, the tip of the index was covered with a full-thickness skin graft sutured into position. In another case, after resection of bone the nail bed was sutured to skin edge and then covered with a split-skin graft. In both the graft took well.

**Burns.**—Patients with severe burns involving whole skin loss or extensive partial skin loss should be referred to the plastic surgeon, as immediate expert local and general treatment is imperative. The importance of early skin cover in the prevention of scar formation cannot be too strongly stressed (Gissane, 1959).

For lesser areas of skin loss, treatment has been carried out at the practice. In cases of superficial partial skin loss the areas have been covered with *tulle gras* after a dusting with an antibiotic powder. The dressing has been completed with gauze wrung out in saline, cotton-wool and a crêpe bandage. The dressing was left undisturbed unless there was pain or an offensive discharge. In some cases an eschar was already present, and the treatment adopted was to wait until the necrotic tissue had separated and then graft if necessary. Eusol or proteolytic digestants—for example, "Proteopax"—were used to speed this separation.

In this series there were nine cases of burns to the hand. Four burns were already infected when the patients were first examined; in two of these cases pinch grafting was successfully carried out after the infection had been controlled. Pinch grafting was also attempted on two of the five non-infected burns, a 100% and a 50% take being obtained. There were no burns sufficiently extensive for split-skin grafting.

#### *Injuries Requiring Skin Grafting.*

There were 26 cases in which skin grafting was attempted—in 19 for avulsion injuries, in four for burns and in three for guillotine injuries. The types of graft employed were as follows: pinch grafts, 11 cases; split-skin grafts, eight cases; resuture of a non-viable flap, five cases; cross-finger flap, one case; full-thickness skin graft, one case.

There were 21 complete takes, three partial takes and two failures. The two failures were with split-skin grafts, the cause being haematoma in one case and infection in the other. One of the partial takes was with a split-skin graft and the other two were with pinch grafts.

The use of the pinch and split-skin graft can be considered to be within the scope of treatment by a general practitioner provided certain principles are observed, as follows. (a) The best time to graft is early, provided the denuded area is not bleeding. Skin will not take over a haematoma. If bleeding cannot be controlled with pressure, a dressing is applied and grafting is delayed for 24 to 48 hours. (b) Skin will not take if applied to a greasy surface. If a greasy dressing has been applied to a raw surface prior to grafting, it is better to apply a dry dressing and wait a day or two. The area will then be far more receptive for a skin graft. (c) Skin will not take over bone or tendon. (d) Skin will not take if applied to damaged or dead subcutaneous tissue, which should always be excised. (e) If the denuded area is extensive and there is doubt as to the correct plastic procedure, the patient should be referred to a plastic surgeon.

In this series split skin has been used in cases of avulsion of pulp skin when there has been only a slight loss of subcutaneous fat and no likelihood of a residual defect. It has been found that avulsed flaps still attached by a small non-viable edge take well when resutured into position, provided they are cleaned of all subcutaneous

fat. Pinch grafts have been used mainly for wounds not involving pulp skin which have been denuded for several days. It has also been observed that pinch grafts continue to grow in the presence of some infection and when bathed in exudate.

The donor site has been the anterior aspect of the arm or forearm. The periphery of the area is infiltrated with 1% "Xylocaine" solution. For obtaining pinch grafts, a needle with a straight cutting edge and a scalpel are all that are required. A Blair's knife is used for obtaining a split-skin graft, but it has been found that a "Durham Duplex" razor blade serves the purpose admirably when a small split-skin graft is required. A greased wooden board is necessary to obtain tension in the cutting of these split-skin grafts.

In applying the graft to the receptor site, the method used has been to apply the skin to a single layer of *tulle gras*, which is then cut to the size of the defect. When in place, the graft is covered with thin layers of cotton-wool moistened in saline. This mould is covered with a layer of dry gauze and a crêpe bandage is finally applied, care being taken to avoid any shearing stress. The cotton-wool dries out to a firm mould and provides a useful splinting action. It has been necessary to use plaster immobilization on only one or two occasions. The dressing is first taken down in six or seven days. The finger, with its inner dressing, is soaked in saline, and when thoroughly moistened the *tulle* and cotton-wool mould is gently teased from the graft with a pair of fine scissors and plain dissecting forceps. If the take is good, the area is gently irrigated to remove any exudate and a fresh layer of *tulle gras* applied. The skin edge adjacent to the graft is painted with 1% mercurochrome solution if there is any tendency towards maceration. A further inspection is made in two or three days and a light dry dressing applied. This is repeated until the graft is secure, the patient being warned about excessive use of the finger in the early stages.

#### *Tendon Injuries.*

There were 14 tendon injuries, ten of which involved extensor tendons to the fingers. There were two cases of severed extensor pollicis longus tendon and one of severed adductor pollicis tendon at its insertion. There was one case of divided flexor tendons in the finger, in which suture was attempted as a primary procedure.

Of the ten extensor tendon injuries, six were sutured as a primary procedure and all healed satisfactorily. In two cases, in which the tendon was partially severed, the tendon was not sutured, and in both it healed without loss of power or function. There were two injuries treated by secondary suture (both seen three weeks after the initial injury). The first was a divided extensor expansion at the level of the metacarpo-phalangeal joint, and the second was a divided central slip of the expansion at the level of the proximal interphalangeal joint. In the latter case the collateral slips of the expansion were approximated over the dorsal aspect of the joint (Charles Rob and Rodney Smith, 1956). Satisfactory results were obtained in both cases.

The extensor pollicis longus tendon was sutured in two cases and the adductor pollicis tendon in one case. In all cases complete return of function resulted. The one case of a severed flexor tendon in which primary suture was attempted was a failure. This occurred early in the series, and it was decided that all subsequent patients with severed flexor tendons in the fingers should either be referred directly to a plastic surgeon or should undergo skin approximation only at the initial stage and later be referred.

In the suture of tendons, adequate exposure was obtained by wound enlargement, a tourniquet being used to obtain a bloodless field. Fine silk ("000") has been used in all cases of tendon suture, and in no case was infection a complication (Bunnell, 1944). Fingers were immobilized in the position of function with the wrist extended (extensor tendon suture) for three weeks and

then supported with a crêpe bandage before physiotherapy was begun.

#### *Nerve Injuries.*

The presence of nerve injury must be determined either at the initial assessment or during exploration of the wound prior to suture. A divided digital nerve may not be detected by testing for sensory loss, and it is only when the wound is thoroughly inspected that the divided nerve is discovered. Digital nerves in the proximal part of the finger and in the palm can be approximated with fine silk with good results. Two such cases were encountered in this series, and the result of suture was successful. Patients with more extensive nerve injury, particularly if there is loss of distance, should be referred to a plastic surgeon.

#### *Infection.*

There were 207 wounds in this series that were considered "clean" or could be made clean by adequate wound toilet. Four (1.9%) were complicated by subsequent infection. In three of these cases infection followed suture of simple uncomplicated lacerations, the infection being mild only. The wounds were healed within twelve days. In the remaining case infection occurred in an avulsion injury and resulted in the failure of a split-skin graft. It is contended that adequate wound toilet and attention to the principles of suture repair are responsible for the low incidence of infection in this series.

#### *Industrial Cases.*

The majority of cases (181) have been industrial. It is important that these injuries receive prompt attention. Other aspects to be considered are as follows:

1. Correct initial certification must be provided, with a clear description of the injury and the treatment carried out.
2. Regular progressive certificates should be given in long-term cases.
3. A good liaison with the employer should be maintained. Telephone contact with the first-aid attendant or personnel manager will overcome many difficulties. A discussion of the type of injury and its relation to the employee's occupation, and explanation of the delay in return to work will contribute to the smooth management of these injuries.
4. The aim must be to get the patient back to work at the earliest possible date. This is determined by the nature of the injury and the type of occupation. Not uncommonly, alternative work which does not jeopardize recovery from the injury can be found. Initially, in this series the patient did not return to work until treatment was concluded. However, it has been found that continuation of work, or early return to work, has not resulted in infection or delay in healing. Each case must be decided on its merits.
5. With good liaison, proper certification and personal attention to the patient, cooperation from the employer, the employee and the insurance company can be obtained in all cases.
6. A full record of the patients' injury, treatment and progress is of great value in those cases involving litigation.

#### *Summary.*

1. A plea has been made for all injuries of the hand to be given the attention that is their just due. The aim in all cases is to obtain primary healing and full restoration of function.
2. Adequate facilities and materials for the treatment of these injuries are within the scope of an average group practice.
3. A procedure has been discussed for assessment and treatment of hand injuries.
4. The results of 220 cases are presented.

#### *Acknowledgements.*

I wish to thank the nursing staff, whose cooperation and attention to detail have been largely responsible for

any success achieved in the treatment of these injuries. I should also like to thank Miss M. Lyons, who has spent much time in preparation of accident cards and in the typing of this article.

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### "SIQUALINE" (FLUPHENAZINE) IN PSYCHIATRIC PRACTICE: A PRELIMINARY REPORT.<sup>1</sup>

By HARRY R. BAILEY, D.P.M.,

Director, Cerebral Surgery and Research Unit, Callan Park,

J. S. BLOW,

Fellow in Psychiatry, Post-Graduate Committee in Medicine in the University of Sydney,

AND

S. G. SANDES, D.P.M.,

Deputy Medical Superintendent, Mental Hospital, Callan Park, N.S.W.

RECENT investigation in the field of psychotropic drugs has directed attention to the greatly enhanced psychic effect of certain fluorinated derivatives of phenothiazine. One of these compounds, 4-3-(trifluoromethyl)-10-phenothiazinyl propyl-1-piperazine-ethanol dihydrochloride ("Squaline", Squibb) has been stated by the discoverers to be extremely potent in its effect on psychic function while having a longer duration of action than any other phenothiazine derivative. An uncontrolled pilot study has been carried out to provide a basis for a decision whether a multi-disciplinary, properly controlled clinical trial is likely to be a worthwhile procedure.

#### *MATERIAL AND METHOD.*

Twenty patients (10 male, 10 female) were selected from the long-stay wards of the Mental Hospital, Callan Park. No detailed criteria for selection were laid down, but it was indicated that we desired chronic patients who presented the most difficult management problems on the wards, and who had not responded significantly to the exhibition of chlorpromazine and its derivatives. The patients resulting from this selection may be described briefly as follows:

1. Diagnostic category. The diagnostic formulations were not reassessed for purposes of this trial. Of a total of 17 patients, 14 (nine male, five female) were suffering from schizophrenia (all types), two (both female) were suffering from Korsakow's psychosis, and one (female) was a congenital mental defective with epilepsy.
  2. Clinical state. This may be summarized as follows: primarily agitated, aggressive, impulsive, seven patients (three male, four female); primarily withdrawn, blocked, mute, seven patients (five male, two female); alternately withdrawn and aggressive, two patients (female); presenting advanced thought disorder, with emotional blunting and incongruity, one patient (male); total, 17.
- Of the originally selected 20 cases, three are not included for the following reasons:

CASE I.—The patient was a male, aged 25 years, suffering from schizophrenia, in whom thought disorder was the outstanding feature. This patient developed severe dystonic symptoms within two days of the start of treatment with the drug, and it was immediately discontinued. This case is discussed under the heading of "Clinical Side Effects", but not included in the results elsewhere.

<sup>1</sup>This is one of a series of interrelated clinical investigations in psychopharmacology currently being carried out at the Cerebral Surgery and Research Unit, Callan Park.



**CASE XIX.**—The patient was a female, aged 48 years, diagnosed as schizophrenic, but presenting aggressive, impulsive behaviour as the outstanding feature. This patient was found to have an enlarged liver during the physical examination and the drug was never exhibited.

**CASE XX.**—This patient was a female, aged 53 years, suffering from general paralysis of the insane (arrested), and presenting with withdrawal and muteness as the outstanding features. This patient developed a physical illness and the drug was never exhibited.

It is not in any way suggested that the foregoing descriptions of the patients are sufficiently complete, but they do represent, from an operational viewpoint, the factors thought to be relevant in a pilot trial of a drug of this kind.<sup>1</sup>

Initially, each patient was examined by a committee of three (H.R.B., J.B., S.G.S.) and its observations were recorded. All patients selected were then reexamined physically and their medical and psychiatric histories were reviewed, with special attention to any evidence of hepatic or renal disease. A biochemical and haematological battery of tests was then carried out on each patient, as follows: (a) serum bilirubin estimation, (b) thymol turbidity test, (c) zinc sulphate turbidity test, (d) serum alkaline phosphatase estimation, (e) blood urea estimation, (f) haematocrit, (g) estimation of the erythrocyte sedimentation rate (when this was thought to be indicated), (h) leucocyte count and differential leucocyte count, (i) blood film examination.

As a routine, therapy was started at a dosage level of 12.5 mg. per day, the dose being later modified in five cases in which this appeared indicated by the clinical response. In two cases the dose was raised (to 15 mg. and 20 mg. per day, respectively), and in the other three it was lowered to 7.5 mg. per day. These quantities were all given in divided doses. No attempt was made in this trial to assess the claim that a greatly increased duration of action permits the administration of less frequent doses of this drug.

It was planned to maintain the patients on the drug for a minimum of three weeks, and this proved possible in all but two cases. One of these patients was withdrawn after only two days because of dystonic symptoms, and is not included in the final results. The other developed a severe Parkinsonian state after 19 days and the drug was withdrawn at this time; this patient is included in the results.

At the end of the three weeks test period, each patient was again assessed by the committee, and its observations of the changes in the patients were recorded. The senior members of the nursing staff of the ward were later also interrogated to obtain further information. The laboratory battery of tests was repeated at this point.

It was decided to continue the drug in 12 cases (five male patients, seven female) for a further period, but this later period is not considered in this report, apart from the use of some of the later biochemical results in the discussion of the side effects.

#### RESULTS.

In assessing the results, the following four groups of symptoms were isolated and considered separately for changes.

1. Agitation. In this area, the results were as follows: improved, five patients (two only slightly); worse, two patients.

2. Withdrawal, muteness. In this area the results were as follows: improved, nine patients (one considerably, three slightly); worse, none.

3. Aggressiveness, impulsiveness. In this area the results were as follows: improved, six patients (one slightly); worse, one patient.

4. State of dress, soiling, etc. In this area the results were as follows: improved, two patients (one considerably).

<sup>1</sup>The evaluation of methodology in clinical trials of psychotropic drugs has been under investigation in this Unit over the past two years (Study DS. 1., to be published).

#### Additional Clinical Observations.

In Case VIII, that of a male schizophrenic, aged 53 years, there had previously been present constant ritualistic behaviour in the form of a complicated kneeling action repeated every couple of minutes. This had been present for years, and was completely unaffected by any other form of therapy. During the current trial it rapidly diminished to an occasional repetition only.

In Case XVIII, that of a female schizophrenic, aged 50 years, there had been marked withdrawal, mutism and frequent minor self-mutilation. This pattern changed to another, in which she made efforts to approach the interviewer closely, while making loud sucking movements. When too close a contact was refused by the interviewer, this patient would then lie down in the "foetal" position and the sucking movements would cease while she was in this position.

This patient had a degree of rectal prolapse which made the recumbent position more comfortable for her, so the significance of the behaviour is difficult to assess. Nevertheless, it was thought that this extremely regressed patient was making improved efforts to communicate.

In Case V, that of a male schizophrenic, aged 30 years, the previous aggressiveness worsened during the trial, and he became self-mutilating for the first time.

In Case XI, that of a female schizophrenic, aged 33 years, there was an increase in negativism and greater difficulty with feeding during the trial.

#### Side Effects.

##### Clinical Side Effects.

The clinical side effects can be discussed under three headings, as follows.

**Abnormal Movements.**—Parkinsonism occurred in three cases. Two of these patients were females, aged 33 and 50 years, and one was a male, aged 30 years. The disability in the female aged 50 years became so great that the drug was withdrawn on the nineteenth day of the trial; this patient had a history of marked Parkinsonian symptoms with other phenothiazine derivatives. The disability in the other two patients was slight and affected only the upper limbs.

**Dystonic Symptoms.**—In two cases symptoms occurred which were thought to be of a dystonic nature. In Case I there developed on the second day of therapy a peculiar state, in which the patient sat bent forward with tongue protruded and salivating copiously, apparently unable to speak or to assume a normal posture.

In Case XVIII, the patient suffered a single attack lasting several hours, in which her gaze was fixed upward. However, on two occasions during a ten-minute observation period she did look at the examiner and quickly looked up again, so the status of this symptom must remain in doubt. The case does present certain similarities to the case of acute dystonic reaction to perphenazine reported by Montgomery and Sutherland (1959).

The patient in Case VIII made a frequent complaint of upper abdominal pain, never previously complained of, for which no clinical cause was apparent, and which disappeared when the drug was withdrawn. Possibly this could have been of a dystonic nature; we have seen two patients under perphenazine treatment misdiagnosed as having acute abdominal disease.

**Changes in Blood Pressure.**—In one case, that of a man, aged 53 years, with normal blood pressure (110/70 mm. of mercury), there were readings as low as 95/60 mm. of mercury on three occasions, but there were no other clinical symptoms or signs of hypotension.

##### Biochemical Side Effects.

**Liver Function.**—No abnormalities were found from the battery of liver function tests, except in the serum bilirubin contents. In nine cases the serum bilirubin level was just above the normal limit, between 1.0 and 1.4 mg. per 100 ml., and there was some tendency for these values to fall after the drug was withdrawn. None of the more elaborate tests, such as the bromsulphthalein test or serum transaminase estimation, were carried out on this group.

**Renal Function.**—Because of the preliminary nature of this trial, no effort was made to control the many extraneous factors which may cause variation in the serum urea content, so any conclusions must be to some extent tentative and subject to correction by a fully controlled study. In 10 cases the serum urea level rose above the normal limit, and in all the level fell to within normal limits after the drug was withdrawn. Unfortunately it was not possible to carry out concurrent chemical and microscopic examination of the urine during this trial.

**Hæmatological Side Effects.**—In no case was any significant change detected by the blood tests performed. It is thought that the battery carried out was sufficient to detect any likely pathological changes.

#### SUMMARY.

1. The most noteworthy change in the patients receiving this drug was the lessening of withdrawal and mutism, with an improvement in the patient's ability to communicate which was quite striking in some cases. Even when the patient remained mute, it was the impression of all three observers that the *rappot* often improved, with the patient attempting to make contact by other than verbal means. In all, nine patients improved in this area.

2. The patients considered to be aggressive and impulsive were less consistently benefited. Six improved, but one became worse.

3. Agitation lessened in five cases during the duration of the trial, but became worse in two cases.

4. Some evidence emerged to suggest that this drug may be toxic to liver and kidney; but this requires further study in a properly controlled trial, including the use of a wider range of tests. There is no evidence of any adverse effect on the hæmatopoietic system.

5. Three patients developed a Parkinsonian syndrome, but in two it was slight. However, the trial extended over a very short period, and more cases may appear over a longer time.

6. Dystonic symptoms appeared in two cases only, unless the abdominal pain complained of by another patient was in some way related to this group.

7. Hypotension was not a problem in this group of patients.

8. No attempt was made in this pilot study to assess the contaminating effect of the additional attention given during the trial to a group of chronic patients. Such an assessment must await a full-scale controlled trial.

9. The results appear to be sufficient to indicate the need for a detailed evaluation of "Squaline" by a controlled double-blind study, with particular emphasis on withdrawn, mute uncommunicative patients.

#### ACKNOWLEDGEMENTS.

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#### PROGNOSTIC SIGNIFICANCE OF THE SERUM PROTEIN CONTENT IN PREMATURE BABIES AND ITS RELATION TO PULMONARY HYALINE MEMBRANE: PRELIMINARY COMMUNICATION.

By W. D. DOMVILLE COOKE, D.C.H., R.C.P. and S. (London),  
Brisbane Women's Hospital, Brisbane, Queensland.

Two observations formed the basis of the present investigation: (i) the work of Gitlin and Craig (1956), which showed that pulmonary hyaline membrane contained fibrin and that a stage of effusion occurred in the formation of

the membrane; (ii) a subsequent observation by myself that premature babies whose birth weight was under five pounds were found to have a much worse prognosis if their total serum protein content was less than 5 grammes per 100 ml. The incidence of pulmonary hyaline membrane syndrome was confined to this group.

These observations suggested the possibility of influencing the stage of effusion, by increasing the colloidal osmotic pressure of the plasma, since this might prevent or decrease the formation of pulmonary hyaline membrane. Such an approach could be entertained only on a prophylactic basis by virtue of the fibrin formation. Achievement in this direction might confer upon those premature babies with lower levels of plasma protein the high immunity to pulmonary hyaline membrane syndrome enjoyed by premature babies with serum protein levels above 5 grammes per 100 ml.

#### Methods of Investigation.

The following methods of investigation were adopted.

This investigation was confined to babies who had a birth weight below five pounds. Samples of cord blood were taken for the determination of total serum protein content and the electrophoretic pattern. The babies were divided into two main groups, those with serum protein contents of 5 grammes per 100 ml. or over (Group I) and those with lower total serum protein levels (Group II). The babies in Group II were subdivided on an alternate basis into Group IIA and Group IIB, the latter serving as controls.

Group I and Group IIB were given the routine treatment of premature babies, with such additions as their clinical condition required. In addition, Group IIA was prophylactically given 4 ml. of a 25% serum albumin solution per pound of body weight, via the umbilical vein, as soon as possible after birth, at the latest within two hours. This dosage was chosen since this amount can be given with safety, and the random serum protein evaluations over a 48 hour period showed satisfactory serum levels. Prior to the administration of the albumin, any raised venous pressure was adjusted. Thus Group IIB was to act as a control for Group IIA. Group I was to be used to check the above-mentioned observation that such babies had a much better prognosis.

#### Results.

The series totalled 61 premature babies with a birth-weight under five pounds. Twenty-five babies constituted Group I, while Groups IIA and IIB were composed of 18 babies each. The total number of deaths in each group and the deaths due to pulmonary hyaline membrane syndrome are set out in Table I.

The causes of death were confirmed by post-mortem examination. One fatal case that presented clinically as one of pulmonary hyaline membrane syndrome was not included, since permission could not be obtained for an autopsy.

#### Serum Protein Levels in Relation to Expected Date of Confinement.

In general, the serum protein level rises as gestation advances. Levels of 5 grammes per 100 ml. are unlikely before 32 weeks, after which the position becomes more varied. In 15 cases with a gestation period of 35 weeks, seven babies had serum protein levels of less than 5 grammes per 100 ml., and eight had values of 5 grammes or over.

#### Total Serum Protein Levels in Relation to Birth Weight.

There is a tendency for the total serum protein levels to rise with the birth weight. It is unlikely that a serum protein level of 5 grammes per 100 ml. will be found in association with a birth weight below 3.5 lb. The picture becomes more varied after this weight is passed. Of 34 babies weighing between 3.5 and 5 lb., 18 had serum protein levels below 5 grammes per 100 ml. and 16 had levels above that figure; the weight scatter was comparable in the two groups.

### Electrophoretic Pattern.

No constant electrophoretic pattern was found to be associated with the pulmonary hyaline membrane syndrome.

### Comment.

The findings in Group I substantiate the previous observations that the prognosis is better for those premature babies who have a total serum protein content of 5 grammes per 100 ml. or over. It is suggested that the routine estimation of the total serum protein content from the cord blood provides at birth a measure of maturity and prognosis.

Comparison of Groups IIA and IIB shows a reduction in mortality in the prophylactically treated group; this appears to be accounted for by the absence of pulmonary hyaline membrane syndrome in this group.

TABLE I.

Group.	Total Number of Deaths in Each Group.	Deaths Due to Pulmonary Hyaline Membrane Syndrome.
Group I ..	Nil	Nil
Group IIA ..	6	Nil
Group IIB ..	12	6

The lower total serum protein levels, which are referred to above, fall within the accepted range of normal for the premature baby. This is not to say that these levels are optimal. Indeed, under certain pathological conditions, the low colloidal osmotic pressure could become a contributory factor. It is suggested that this may be the case in pulmonary hyaline membrane syndrome. However, it is not suggested that the low serum protein levels are causative. Whether or not the syndrome develops when the baby is exposed to the causative factors may depend upon the severity of these factors on the one hand, and on the level of the osmotic pressure of the serum proteins on the other.

The method of prophylaxis outlined above only maintains balance, and therefore it would seem unlikely that it will be found effective under all circumstances. For example, it has been found, as would be expected from the pathology, that once the signs are established the method is useless. Similarly, in those rarer cases in which signs are present from birth, presumably the condition would not respond or might require earlier administration of serum albumin—that is, directly resuscitation was completed. However, a trial of this must await the occurrence of such cases.

An accurate test is required to show which babies with low serum protein content are in danger of developing pulmonary hyaline membrane syndrome. In the present state of our knowledge, this will not be easy. The difficulty is emphasized when one considers the various suggested aetiological factors—excess of oxygen (Gellis, 1952), excess of carbon dioxide (Kloss von Karlerferdinand, 1957), aspiration of liquor amnii (Johnson and Meyer, 1925), and the absence or delayed appearance of a substance capable of attaining a low surface tension in the lungs (Avery and Mead, 1959).

The evaluation of serum albumin as a prophylactic agent must await the extension of this series; however, there is evidence, both here and in the previous observation, to support the claim that babies whose birth weight is under five pounds have a much better prognosis if their total serum protein content is 5 grammes per 100 ml. or over.

### Summary.

1. Babies whose birth weight is under five pounds have a much better prognosis if their serum protein content is 5 grammes per 100 ml. or over.

2. In a group of premature babies given 25% serum albumin in a dosage of 4 ml. per pound of body weight, as soon as possible after birth, no cases of pulmonary hyaline membrane occurred. This condition was confined to the untreated control group.

3. Attention is drawn to the necessity for a test to indicate which babies with a low serum protein level are in danger of developing pulmonary hyaline membrane syndrome.

4. It is considered that the evidence presented warrants further investigation in this direction.

### Acknowledgements.

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### Reviews.

**A Primer of Water, Electrolyte and Acid-Base Syndromes.** By E. Goldberger, M.D., F.A.C.P.; 1959. Philadelphia: Lea and Febiger. Sydney: Angus & Robertson, Limited. 7½" x 5", pp. 322, with illustrations. Price: 66s.

UNTIL ten or fifteen years ago, although clinicians paid some lip service to fluid balance, dehydration, acidosis and alkalosis, the basic principles were understood by few. Now, thanks to the clear thinking and writing of men like Verney, Gamble and Pitts, the difficult principles involved are becoming more widely understood, and certainly their significance is almost universally appreciated. Partly responsible for this has been the flow of monographs and textbooks, varying from simple introductions directed to the medical student and general practitioner to the extensive and detailed works critically reviewing the whole field of study. The latest contribution by Dr. Emanuel Goldberger styles itself a primer, and is concerned with pathogenesis and treatment of clinical states related to fluid and electrolyte disturbance. The book is written clearly and simply; there is no attempt to consider fundamental physiology, and controversial and theoretical matters are avoided. This has led to a certain dogmatism—for example, the confidence with which the volume receptor is located in the skull and thirst receptors in the hypothalamus. The author emphasizes the confusion which has arisen in the terminology of acid and base relationships, and describes a rational approach. He rather neatly emphasizes his point by occasionally falling into the same confusion himself throughout the text. It is clear that he is a clinician, and some of his biochemistry appears to be influenced by teleological rather than chemical principles. Nevertheless, the reader is left with an orthodox and practical approach to the clinical problems discussed.

**The Complete Cookery Book for Diabetics.** By Iris Holland Rogers; second edition; 1959. London: H. K. Lewis & Company, Limited. 8½" x 5½", pp. 140, with 23 illustrations. Price: 6s. (English).

THE second edition of this book has been extended to include further diabetic recipes, a table of measures, a table of food composition figures and equivalents in terms of the "line-ration" scheme. These additions will no doubt be welcomed by the English diabetic, but unfortunately are apt to be confusing to the Australian patient.



English (McCance and Widdowson) and Australian (Osmond and Wilson) food composition tables are not interchangeable. The difference is not significant as far as the staple foods go, but some of the common proprietary lines mentioned in the book are very different from Australian foods carrying the same name. The tables of food measures present a similar problem. The English standard measuring cup is apparently 7 oz. while the Australian is 8 oz.

The author assumes that a diabetic treated without insulin will not be allowed more than 100 grammes of carbohydrate per day. This is not necessarily the general practice here, and for this reason the paragraph headed, "Diabetics who do not take insulin", should be ignored.

Miss Rogers is doing a valuable service by showing the diabetic patient how to vary his basic diet to satisfy his appetite and avoid monotony, and how to modify foods in case of illness and where normal facilities are not available. However, because of the difference in food composition tables and standard measures, the Australian diabetic would be well advised to limit his use of the book to the recipes, rather than experiment with new recipes based on the figures given. Those diabetics who are able to prepare a conversion table for themselves could, of course, do so; but this would defeat the author's objective, which is to help the diabetic patient to plan interesting and varied menus easily.

**Inborn Errors of Metabolism.** By David Yi-Yung Hsia, M.D.; 1959. Chicago: The Year Book Publishers, Incorporated. Sydney: W. Ramsay (Surgical) Limited. 9" x 5½", pp. 260, with 57 illustrations, 69 charts and 5 tables. Price: £5 4s. 6d.

THERE has been rapid growth in understanding and recognition of biochemical and genetically determined disorders in recent years. This book is the first to attempt to embody our new knowledge in a small volume. Dr. Hsia's work on neonatal and congenital causes of jaundice and his position as director of the genetic clinic at the Children's Memorial Hospital in Chicago provide him with the essential background and interest for this task.

The presentation is divided into six parts, with an appendix describing the laboratory procedures used in the detection of inborn errors of metabolism. In the first part, disturbances of molecular structure such as the hemoglobinopathies are considered, and in the second disturbances of the molecular synthesis, such as agammaglobulinemia and hemophilia. Next comes a section on disturbances of molecular function, or enzyme defects. These are grouped under amino-acid disorders, such as albinism, carbohydrate disorders, endocrine disorders, disorders of pigment metabolism and other probable enzyme disorders. The fourth part considers disorders in renal transport mechanism. The fifth part contains a brief account of some disturbances of unknown etiology, and includes disturbances of lipid metabolism, the muscular dystrophies and a number of miscellaneous disorders. In the last part other conditions which may come to be regarded as inborn errors of metabolism are briefly listed—with a small series of misprints.

Exception might be taken to the author's complete separation of cystinosis and Fanconi rickets without even mentioning the widespread view that these two conditions are identical. The brevity of a number of the descriptions reduces them to little more than tantalizing or annoying snippets. While the few references listed are well selected, they would sometimes provide an inadequate guide to the management of a particular disorder. This was noted in reference to salt-losing adrenal hyperplasia.

This book was written primarily for the general practitioner and house-officer, but it is believed that in this country it will appeal more to the paediatrician and physician as an *aide-memoire* and source of references.

**Color Atlas and Management of Vascular Disease.** By W. T. Foley, M.D., F.A.C.P., and I. S. Wright, M.D., F.A.C.P.; 1959. New York: Appleton-Century-Crofts, Inc. 10" x 7½", pp. 184, with many illustrations. Price not stated.

THIS is an unusual book. To those acquainted with the cost of colour illustrations, the presence of almost 200 colour pictures within a space of some 170 pages is amazing.

The book consists of seven chapters dealing broadly with the main subdivisions of vascular diseases: arterial diseases, venous disease, lymphedema, vasospasm and diseases in which it plays a major role, aneurysm, diseases of small blood vessels, blood vessel tumours. The chapters

are divided into sections, each comprising a short discussion dealing mainly with treatment and followed by colour pictures (often several for one patient) and case notes.

The book is beautifully printed on art paper. The pictures are usually very good and representative of the condition illustrated, although the colour is not always true and many of the limbs have a sunburned appearance. The pictures of acrocyanosis (page 89) and livedo reticularis (page 90) show red hands rather than blue.

The text is inferior in quality to the pictures. Of necessity, the discussion is short and not likely to be of great help to a doctor confronted with a particular problem. In the section on the treatment of chronic arterial insufficiency (pages 5 and 6), no distinction is made between the patients whose main symptom is intermittent claudication and those whose main symptoms are due to skin ischaemia, who present quite different problems. It is stated that "sympathectomy is only of value in rare, carefully selected cases", which is contrary to the experience of many workers who have found it of the greatest value in skin ischaemia. Arterial grafting, the treatment of choice in intermittent claudication, is not mentioned.

Diffuse statements, such as "these conditions [referring to Raynaud's phenomena and other vasospastic disorders] may be primary, or they may develop secondarily to almost any of the dozens of vascular diseases" (page 85), are not very helpful. The small number of chapters leads to artificial pigeon-holing. It is strange to find cryoglobulinemia (in which there is a physical change in the blood in response to cold) and periarteritis nodosa (in which there is a well-defined structural lesion of arterial walls) included in the chapter on vasospasm.

This is an interesting "color atlas", but not a particularly helpful book on the "management" of vascular disease.

**The Year Book of Endocrinology (1958-1959 Year Book Series).** Edited by Gilbert S. Gordan, M.D., Ph.D., F.A.C.P.; 1959. Chicago: The Year Book Publishers, Inc. Sydney: W. Ramsay (Surgical) Limited. 7½" x 5", pp. 384, with 83 illustrations. Price: £4 2s. 6d.

THE 1958-1959 Year Book of Endocrinology is again edited by G. S. Gordan and retains the same lay-out as other recent volumes. In the introduction, Gordan states that the year 1958 has again been one of rapid advances in endocrinology. He notes as one of the most fascinating developments of the year under review the discovery of the way in which the body controls the release of aldosterone; it was discovered independently by two investigators, G. Farrell and F. C. Bartter, that stretching of the right atrium of the heart reduces the output of aldosterone, whereas stretching of the left atrium does not. Another outstanding achievement has been the preparation of an effective pituitary growth hormone by M. S. Raben from human pituitary glands, removed surgically or at autopsy. The application of the techniques of immunology has brought further advances in an understanding of thyroid disease. The hypoglycaemically-active sulphonamides and the chemically unrelated diguanides have provided a fresh stimulus to clinical and basic investigations on diabetes mellitus. These and other notable advances are singled out by Gordan for special mention in his introductory survey of the field. Special articles are contributed by Bartter on the control of aldosterone secretion and by H. M. Grumbach on the sex chromatin pattern and human sexual anomalies, the latter already slightly out-dated by recent discoveries in the study of human chromosomes. This volume deals with a section which is as fascinating as any of the rapidly advancing frontiers of medicine, and makes it plain that there is no slowing in the rate of new and exciting discoveries.

**Current Medical Research: A Reprint of the Articles in the Report of the Medical Research Council for the Year 1957-1958, 1959.** London: Her Majesty's Stationery Office. 9½" x 6", pp. 46, with illustrations. Price: 3s. 6d.

This valuable little pamphlet, which is published both as a part of the annual report of the Medical Research Council and as a separate reprint, gives a very useful account of progress in a selection of the projects sponsored by that body. It is a praiseworthy attempt to keep interested medical, scientific and lay members of the public informed about the more important findings of medical or biological concern in this work, and it is the policy of the Council that all projects for which it is responsible should be so featured from time to time. It should be noted that, though these articles are published

in the report for 1957-1958, in fact they embody the information available up to about May, 1959. The first of the 12 articles gives a brief account of the Council's laboratory for research on tropical medicine in Gambia. The next discusses some recent work on hyperendemic malaria in the same territory. A chapter on intracellular organelles discusses some of the results obtained in the study of the internal organization of the cell by modern microscopic techniques. Articles on microbiology, include those on the viruses of trachoma and inclusion blenorrhoea, on progress towards cultivation of the leprosy bacillus, and on colicine typing in the epidemiology of Sonne dysentery. A chapter on cancer-producing viruses and their immunology indicates some of the complexities of this type of research. Another on research in general practice discusses the work of the Council's Epidemiological Research Unit and other work of a similar nature. Other subjects discussed are ultramicro-analysis, the performance of coal-miners in hot atmospheres, mammalian fertilization and the rehabilitation of chronic schizophrenics. Each article gives a brief account of the background of the work in question and a useful list of references to papers on the topic under discussion.

**Adolescent Rorschach Responses: Developmental Trends from Ten to Sixteen Years.** By Louise Bates Ames, Ph.D., Ruth W. Métraux, M.A., and Richard N. Walker, Ph.D.; first edition; 1959. New York: Paul B. Hoeber, Inc. 9½" x 6", pp. 327. Price: \$8.50.

This volume comes from the Gesell Institute of Child Development, and is a strictly technical volume for psychologists interested in the Rorschach test. It is a sequel to the authors' earlier work "Child Rorschach Responses", in which they traced the changes and development in the character of Rorschach responses between the ages of two and ten years. The present volume continues this survey with a detailed longitudinal study of development trends and sex differences in the Rorschach responses of 100 children aged from 10 to 16 years. The authors believe that it should be of practical usefulness to clinical psychologists, because it presents descriptions of characteristic findings at successive ages for a large group of bright, normal adolescents. It thus provides a background against which individual Rorschach records can be judged. The book is divided into three parts. The first part is broadly explanatory and a discussion of the method. In the second part one chapter is devoted to each year between the ages of 10 and 16 years. The third part discusses the longitudinal survey of individual subjects and sex differences, and concludes with a general discussion and a summary. There is a short bibliography of 58 references.

**The Army Medical Services: Campaigns, Sicily, Italy, Greece (1944-45).** By F. A. E. Crew, F.R.S.; Volume 3, "History of the Second World War, United Kingdom Medical Series"; editor-in-chief, Sir Arthur S. MacNalty, K.C.B., M.A., M.D., F.R.C.P., F.R.C.S.; 1959. London: Her Majesty's Stationery Office. 9½" x 6½", pp. 681, with 130 illustrations and 58 tables. Price: 100s. (English).

This volume covers the campaign in Sicily during July and August, 1943, and the hard-fought struggle in Italy from September, 1943, until May, 1945. It includes also the seizure and loss of some of the Aegean Islands and the return to Greece (1944-1945). This is regarded as the period in which the efficiency of the Army Medical Services reached its highest peak. The editor writes:

By 1944 the Army Medical Services had become such that it could be stated without fear of contradiction that never before, either in war or in peace, had everything that medicine had to contribute to the promotion of health, to the prevention of disease and to the treatment of disease and of injury, been as easily and as readily available to the individual member of a community as was the case in Italy.

New techniques and therapeutic measures had been developed under the stimulus of the war-time needs of the nation. The efficient use of new units, such as field dressing stations, field surgical units and field transfusion units, had been worked out, and a large number of medical personnel, male and female, in all ranks had been fully trained in the field.

The terrain was difficult, including snow-capped mountains and sweltering valleys, often flooded. Instead of rapid advances and occasional retreats, to which the troops were accustomed in the desert, the campaign consisted of a succession of bitterly contested battles, frequently with

heavy casualties. Evacuation was often difficult with normal ambulance facilities; more use was made of stretcher-bearers. Stretcher-carrying jeeps were sometimes of service, but air evacuation was preferred, and came more and more to be regarded as a normal and essential part of any operational plan, with constant urging that Army Medical Services should have their own ambulance aircraft.

The general standard of living of the local populace, low at any time, had deteriorated under war conditions. Privation, overcrowding and insanitation were the rule. The many endemic diseases constituted a serious menace to the health of the troops. Their control was frequently a responsibility of the Army Medical Services until the Allied Military Government could take over. The Allied Army was composed of various national groups, each capable of making its own peculiar contribution of infection. Small wonder, then, that the incidence of disease was high and at times interfered seriously with tactical planning. Malaria was endemic in Sicily and in many parts of Italy. Anti-malarial measures provided for the troops were at first quite inadequate, and even such as were available were not fully utilized. The incidence of the disease reached alarming proportions requiring drastic action. A measure of control was achieved by suppressive drugs, protective clothing and destruction of mosquitoes and their larvae by increasing numbers of malaria control units with which the Australian Imperial Forces were familiar in New Guinea. It was gradually realized that control of malaria in a malarious district was one of the most important duties of an army commander.

Almost as great a menace was venereal disease, which was rife in the community in a very virulent form. Control of the source of infection, prophylaxis, education and improved amenities produced some improvement; but it remained a serious problem throughout, although greatly lessened when penicillin became freely available. One medical officer reported: "The amounts of penicillin used are enormous, and, considering its previous scarcity, shocking, but the results achieved in restoring man power are immense." Unfortunately it seemed that this easy means of cure encouraged promiscuity.

Of other endemic diseases enteric fever was never a serious problem among the troops, and dysentery only occasionally caused concern. An epidemic of typhus in Naples ended abruptly after the "delousing" of a million and a half of the inhabitants with D.D.T.

The success of the Army Medical Services in conserving manpower was a major factor in attaining ultimate victory in a contest in which the antagonists were fairly evenly matched.

This third volume on campaigns well maintains the high standard and interest of its predecessors.

## Books Received.

[The mention of a book in this column does not imply that no review will appear in a subsequent issue.]

"The Neurochemistry of Nucleotides and Amino Acids: A Symposium of the Section on Neurochemistry, AAN", edited by Roscoe O. Brady, M.D., and Donald B. Tower, M.D.; New York and London: John Wiley & Sons, Incorporated. 9" x 5½", pp. 304, with 62 illustrations and 64 tables. Price not stated.

"Clinical Obstetrics and Gynecology", vol. 3, number 1, March, 1960. "Obstetric Emergencies" edited by Martin L. Stone, M.D. "Pediatric Gynecology", edited by John W. Huffman, M.D. New York: Paul B. Hoeber, Incorporated. 9½" x 6", pp. 264, with many illustrations. Price: subscription \$18 a year.

"A Symposium on pH and Blood Gas Measurement: Methods and Interpretation", edited by Ronald F. Woolmer, V.R.D., B.A., B.M., F.F.A.R.C.S., assisted by Joy Parkinson, B.A.; 1959. London: J. & A. Churchill, Limited. 5½" x 8½", pp. 218, with 48 illustrations. Price: 30s. (English).

"Clinical Physiology", edited by E. J. Moran Campbell, B.Sc., Ph.D., M.D., M.R.C.P., and C. J. Dickinson, B.A., B.Sc., B.M., M.R.C.P., with a foreword by Sir Robert Platt, Bt. M.D., M.Sc., LL.D.; 1960. Oxford: Blackwell Scientific Publications, Limited. 8½" x 5½", pp. 542, with 29 figures and 26 tables. Price: 50s. (English).

## The Medical Journal of Australia

SATURDAY, JUNE 4, 1960.

### HUMANITY CALLS.

ONLY the stony hearted and the stony broke are likely to be able to resist the appeal of World Refugee Year. A short time ago<sup>1</sup> we discussed certain aspects of the world refugee problem, especially from the medical point of view, and pointed out then that what these multitudes of homeless people wanted was what most of us take for granted—a country and a home and something to live for. Their ever-present need is for the things that keep them alive and able to carry on from day to day—shelter, food, clothing and some sort of medical care. But it is just as important to them, and even more important to the rest of the world, that they be given the chance to undergo rehabilitation in some degree at least, either where they are or in a new land that is to be their own and their children's home. Sincere and, within inescapable limits, successful efforts are already being made at rehabilitation and at trying to avoid the tragedy of children growing up quite aimlessly without security or purpose in their lives. Among the Arab refugees in the Near East, for example, much has been done by UNRWA (United Nations Relief and Works Agency) and UNESCO through schools, vocational training centres and other institutions and through local development and resettlement schemes to train and employ refugees and to make them self-supporting so that they may retain their self-respect. Much more, however, needs to be done.

There is no shortage of agencies, governmental and independent, working amongst refugees. There are people of experience and ability already on the job who know how to go about the task and will get on with it if they are given the resources. Perhaps there are just two things asked of the ordinary citizen who knows the security and satisfaction of "belonging": first, personal contribution of money, great or small according to his resources, and second, the creation of a climate of opinion that will increasingly open countries to refugees, even if it involves some local self-sacrifice. The second of these requires a good deal of thought, but we should hope that the medical profession, versed as it is in many aspects of human need, might see the point of it and offer a lead in the community. The opportunity

to respond to the first requirement is immediately at hand. On Sunday, June 19, a door-to-door collection is to be made throughout Australia for the World Refugee Year Appeal. This is being organized by citizen committees of the highest standing in each State and in local areas and aims to reach everybody. Donations may of course also be sent direct to the various appeal committees at any time and, if of £1 or more, are allowable income tax deductions. The hope, however, is that the response on June 19 will be universal and generous and counted as a privilege by all sections of the community.

### THE MEDICAL TREATMENT OF MINORS.

A CONSIDERABLE dilemma may be created for the doctor who sees the need to administer certain forms of medical treatment to minors when the parents or legal guardians are either not available or unwilling to give consent for the treatment recommended. Two recent amendments to the *Public Health Act* in New South Wales have been designed to overcome some of the difficulties involved, and these, although applicable only within New South Wales, will be of general interest. One of the amendments, that relating to blood transfusions for minors, was referred to in these columns recently.<sup>2</sup> The other amendment relates to the immunization of minors against infectious disease. According to recent advice from the N.S.W. Department of Public Health, this legislation has resulted from the fact that cases have been brought to the notice of the Department in which it was not possible to arrange for young children to be immunized because they were being cared for by relatives or other persons who could not give a valid legal consent for such immunization. In addition, it is thought that there may be numbers of children in benevolent homes or church homes whose immunization cannot be arranged because they are orphans or by reason of the fact that neither the controlling authorities of the homes nor the children's other relatives can give a valid consent for their immunization. The legal position has been that only a parent or legal guardian could give a valid consent for the immunization of a minor, but the amendment to the *Public Health Act* that has now been made provides a means whereby, subject to certain requirements, the consent of the person for the time being having the care or custody of a minor may be given for the immunization of that minor. This will include relatives or persons other than a minor's parents or legal guardian, and also the controlling authority of any benevolent home or church home, provided that any of these can be regarded as having the care or custody of the minor for the time being. The new section also provides that a council (a local government authority) or a legally qualified medical practitioner may immunize any minor against an infectious disease if after diligent search and inquiry they have been unable to find the parents or surviving parent or any other person legally entitled to consent to the immunization. In this connexion it is considered that medical prac-

<sup>1</sup> *MED. J. AUST.*, 1960, 1: 625 (April 16).

<sup>2</sup> *MED. J. AUST.*, 1960, 1: 661 (April 23).



tioners should decide each case on its merits, having in mind any action which may have been taken by the person having for the time being the care or custody of the minor to locate the parents, surviving parent or other person legally entitled to consent. For information the following are the most relevant subsections of the new section (39A) which deals with this matter:

(3) A council and any legally qualified medical practitioner whether acting for or on behalf of a council or otherwise may immunise any minor against an infectious disease if—

(a) the council or legally qualified medical practitioner after diligent search and inquiry has been unable to find the parents or surviving parent of such minor or any other person legally entitled to consent to the immunisation of such minor against infectious disease; and

(b) the consent of the person for the time being having the care or custody of such minor has been obtained to such immunisation.

(4) Any consent given by the person for the time being having the care or custody of a minor to the immunisation of such minor against an infectious disease shall, for the protection of the council or legally qualified medical practitioner immunising such minor in accordance with such consent and of any person concerned with such immunisation, have the same effect as if such consent had been given by the parents of such minor.

(5) The powers conferred on a council and any legally qualified medical practitioner by this section shall be in addition to and not in derogation of any other powers of the council and legally qualified medical practitioner in relation to the immunisation of minors against an infectious disease.

It will be noted that the provision for immunization does not allow for the overriding of the authority of parents that is provided for in the section on blood transfusions. This is reasonable. It is possible at times to assert categorically the life-saving value of a blood transfusion and the great danger involved in withholding or even delaying it. The position is not quite the same with immunization, even though its value in certain diseases is beyond any reasonable question. As was agreed in our previous discussion on blood transfusion, the rights of parents over their children cannot lightly be put aside by any outside authority, especially when the parents show every sign that they are sincerely concerned for the welfare of their children. In the totalitarian country there is no hesitation about invading the private life of the individual or the family circle where it suits the State. In a democracy this is regarded as a violation of normal rights, to be countenanced only for the strongest reasons. The present legislation would seem to conform to democratic principles.

## Current Comment.

### CURRENT COMMENT ON AN OLD JOURNAL.

A CASUAL PERUSAL of old medical journals may be rewarding and interesting; for example, the following quotable items were culled from the *Medical Times*, Volume 6, 1842. In a letter to the editor signed "Junior Student" there is an extract from the *Sunday Times*:

*Extraordinary Operation.*—Some days ago a young woman was brought into Westminster Hospital under very distressing circumstances, having overstrained herself and burst an artery, through which every particle of blood escaped from her body; after losing more than a pailful of blood she was placed in the

Adelaide ward in the full expectation of her dying within a few hours. A consultation having taken place between Dr. Roe of Hanover Square, Dr. Bright and five other medical men it was determined to attempt transfusion of blood from healthy persons into her body. The first experiment was made in the presence of the above named, when a healthy young woman was bled and the fluid transferred to the veins of the patient. Thursday last the same was renewed and on Friday the reverend chaplain of the hospital permitted himself to be operated upon with the same view. Yesterday (Saturday) the patient though, of course, in a very weak and precarious state, gave considerable ground of hope. This is the second occasion upon which the operation has been performed in Westminster Hospital; on the former occasion the transfusion was completely successful.—*Sunday Times*, March 27th, 1842.

The object of "Junior Student" was not to draw attention to an unusual procedure but to rebuke Dr. Roe for advertising, in which he was supported by the editor with the comment: "The special mention of his (Dr. Roe's) residence . . . certainly raises a suspicion which calls for his most decided disclaimer." Next week's edition of the *Sunday Times* announced that "the young woman upon whom the operation of transfusion of blood had been performed is declared out of danger, the experiment having fortunately been completely successful".

When was the word "pneumonitis" first used? In an article in this issue of the *Medical Times* by J. Jeffreys entitled "On the Atmospheric Treatment of the Lungs" it appears several times, as if it was the ordinary word for inflammation of the lung, although the word "pneumonia" is also used in this article. Browsing on we find on page 41 a character sketch of John Abernethy by an anonymous author who was apparently a colleague or student. It is an entertaining article of historical interest. Sir Benjamin Brodie's recipe for indolent ulcers—a liniment made of balsam of Peru and the yolk of an egg—appears on page 50. Elsewhere plaster of Paris is strongly recommended for the arrest of dental hæmorrhage as being "the most perfect plug that could be applied". Another writer (page 127) recommends the replacing of the extracted tooth as "the most certain and easy remedy he has ever found; in a few days it becomes firm and often serviceable". James B. Thompson (page 151) remarks: "It is a very common opinion among the Irish peasantry that causing a dog to lick a sore of any description will be one of the speediest ways of healing up and permanently curing that wound or sore."

Dr. M'Kinnon of the Edinburgh Lunatic Asylum seems to have been ahead of his times in practising what he calls the moral treatment of the insane. It consists, he says, of "encouraging habits of self control, in gently exercising the faculties of the mind . . . in affording scope for the pursuit of useful employment and gratifying tastes. . . . Something more is required in an asylum than provisions for the safe keeping of its inmates. The Scholar should have his library, the artist his studio, . . . every one society and the means of recreation and amusement. Opportunities should be afforded for the inmates to lead, so to speak, a rational life. . . . The inmates have been encouraged to engage in such pursuits as were congenial to their tastes. . . . Meetings of the inmates for various purposes have been held."

A remarkable plastic operation is recorded on page 160 by M. della Fanteria, who attended a girl with two fingers cut off by accident. He found the fingers in some bran into which they had fallen. He reunited the fingers to the hand by strapping and sutures. "At the end of a few days union was perfect and the girl thoroughly recovered the free use of her fingers, the articular motions continuing. This case is verified by the celebrated Vacca and by Professor Centofanti." Did someone ask for the salt? Nearly as remarkable is the following: "Dr. Foulhoux of the Hotel Dieu has lately employed with success the Mexican plant Cavadella in a case of hydrophobia which appeared hopeless. He administered to the patient 19 drachms and had the satisfaction of seeing him gradually improve. He shortly after left

the hospital perfectly cured." A mistaken diagnosis or a forgotten remedy?

Comment seems to have been more free and easy in those days. Under the heading "To Correspondents" on page 344 are these remarks about a rival journal, the *Medical Gazette*: "... the inane pomposity, the threadbare respectability and sycophantic unprincipledness which form the stock in trade of the ever tiring but untired editor of the 'Medical Gazette'. We now learn ... that the journal's responsibilities rest on Mr. Paget, a young gentleman filling with great gentility some inferior situation in St. Bartholomew's Hospital."

From a French hospital comes a report on page 349 about a patient with "severe and extensive ulceration" of the abdominal wall. Almost every form of treatment, including the actual cautery, had failed. "Powdered rhubarb was now applied in very small quantity on account of the violent irritation it produced. ... The powder was applied every other day for about six weeks, when the ulcers had nearly healed and ... in about a fortnight he was able to leave the hospital quite recovered." For good measure there is a long translation from a current *Medizinische Zeitung* on "Wounds of the Heart" containing reports of many cases, not all fatal. The price of the *Medical Times* was fourpence a copy, and it was published weekly.

#### PROPOSED STANDARD FOR CAR SAFETY BELTS.

The completion of a draft proposal for an Australian standard specification for safety belts and harness for motorists has been announced in Sydney by the Standards Association. The decision to prepare a standard was made last year following requests from road safety organizations in every State. These organizations had been impressed by reports from overseas which proved that the wearing of seat belts could reduce the severity of injuries to motorists and passengers involved in accidents. It was felt, however, that belts would be of little value unless standards were established for the strength, design and method of anchoring. The Standards Association states that the draft standard covers those points, and that wearers of safety belts that comply with its requirements can be assured that the protection provided is the best available. Belts and harness are usually made of webbing, and tests carried out by the Association on webbing readily available in Australia showed that it had a greater strength and less stretch than webbing used in similar overseas equipment.

Before the draft is finally adopted as an Australian standard, the Association is inviting public comment on the proposals with a view to possible improvement. Anyone who is interested in commenting on the draft can obtain a copy free by applying to any of the Standards Association's offices in the capital cities and at Newcastle. The reference number of the draft is Doc. 464, and the full title is "Safety Seat Belts and Harness Assemblies for Motor Vehicles". The Association wants all comment to reach it by June 30 this year.

#### CHEMOTHERAPY OF MALIGNANT TUMOURS BY EXTRACORPOREAL PERFUSION.

By isolating the circulation to a part bearing a malignant growth and perfusing it through an extracorporeal circuit with a chemotherapeutic agent such as one of the nitrogen mustard compounds, systemic toxicity is avoided, and yet a large amount of the agent is delivered to the growth and its neighbourhood. The technique for this and the results of its use are described by W. Gerald Austen, Anthony P. Monaco and others in two interesting papers.<sup>1</sup> One of these papers deals with pelvic growths and the other with growths of a limb. In the pelvis the blood vessels cannot be completely isolated, and there is

danger of systemic toxicity, but in the limbs vascular occlusion is easier, and here limitation is imposed by local tissue tolerance rather than by systemic toxicity.

The technique for treating pelvic growths involves retroperitoneal occlusion of the aorta and the inferior vena cava, and occlusion of the femoral vessels by means of pneumatic cuffs around the upper part of each thigh. The perfusion is carried out through the femoral vessels, which are exposed proximally to the pneumatic cuff. Number 14 plastic cannulas are inserted into the femoral artery and vein and passed upwards into the external iliac vessels. The perfusion is made through a modification of the Kay-Cross Rotating Disc Oxygenator. Radiation therapy can be given later without danger of over-dosage to the tissues involved. Seven cases are presented, and in four there was regression of growth.

The second paper describes the treatment of Kaposi's sarcoma of the leg. Intravenous administration of nitrogen mustard has proved disappointing in the few cases so far reported, but some encouraging results have followed intraarterial injection. Austen and Monaco here present two cases in which the Kay-Cross oxygenator was used with vascular isolation. In both cases there was "gratifying rapid remission", without systemic toxicity or local sequels.

#### THE CHANGING PROGNOSIS OF APPENDICITIS.

In 1934 C. T. Officer Brown wrote a paper<sup>2</sup> on acute appendicitis which included tables of the trends in mortality from this condition up to that time. From these it was apparent that, after the dramatic improvement in outlook during the first decade of the century, there had been little, if any, improvement in the results of operation during the twenty years preceding Officer Brown's review, while there had been actually a small but progressive increase in the number of deaths per 100,000 attributed to appendicitis in the population as a whole. Similar trends had been observed in Britain and America, and the position at that time was causing some concern.

D. S. Kidd of Adelaide has recently<sup>3</sup> brought Officer Brown's figures up to date and presents mortality statistics relating to appendicitis since 1933 for both South Australia and Australia as a whole. As might be expected from the changing outlook of surgery in general during that time, these statistics show a most gratifying improvement. In the six years up to 1939 the mortality rate of appendicitis in Australia had fluctuated between 7 and 9 per 100,000, but in 1940 the steep fall began, which by 1952 had brought this rate down to 2.0 per 100,000, since when it has remained below this figure; the last two years for which Kidd presents figures are 1956 (1.64) and 1957 (1.61).

One of the most instructive parts of Kidd's review is his analysis of deaths from appendicitis according to age group. This emphasizes again the greatly increased danger of the condition among the elderly, in which group the decline in mortality since 1933 has been least marked. The mortality rate from appendicitis among people over 70 years of age still stands at about 9 per 100,000.

In discussing the reasons for the improved prognosis of appendicitis Kidd makes a detailed comparison of two series, each of 786 cases, from the Royal Adelaide Hospital, the first relating to the years 1936-1938, the second to the year 1956-1957. He concludes that there is no evidence of any change in the character of the disease, and that the most important factors contributing to the improved prognosis are antibiotics, intestinal decompression and intravenous infusions. However, we should not forget that operation for acute appendicitis still carries a small mortality risk, and that the size of this risk in any series depends to an important extent on the number of cases of appendicitis with perforation included in that series.

<sup>1</sup> MED. J. AUST., 1959, 2: 407 (September 29).

<sup>2</sup> Aust. N.Z. J. Surg., 1960, 29: 250 (February).

<sup>3</sup> New Engl. J. Med., 1959, 261: 1037 and 1045 (November 19).

## Abstracts from Medical Literature.

### ORTHOPAEDIC SURGERY.

#### Trochanteric Fractures of the Femur Treated by McLaughlan Nail and Plate.

J. C. FOSTER (*J. Bone Jt Surg.*, November, 1958) reports a study of 142 fractures of the trochanteric region treated at the Bradford Accident Service. The patients had all been admitted from an area with a population of about 450,000. Most patients were operated on, except a few who were moribund on admission to hospital. The average delay before operation was 6.4 days. Any patient who was kept longer than 24 hours before operation was treated in Russell traction. The author discusses the technique of the operation and the type of McLaughlan plate used. An analysis of the strength of nail plates of different patterns is presented. The author points out that the advantages of the operation are that the patient can be out in a chair in 48 hours and up on crutches as soon as possible. He notes that too early weight bearing is always likely and emphasizes the importance of the medial cortical buttress in taking some of the pressure of the pin and the plate. If the pin has to take all the weight then there can be a pressure up to 634 lb. per square inch if the plate is set at an angle of 135°. This is above the breaking strain of even the new type of McLaughlan device. The excess strain is even greater if the hip is stiff or fixed. A table is given of the bending movement of varying types of plates. The new McLaughlan plate is the best and bends at about 484 lb. per square inch. Titanium is about half as elastic as "Vitalium". The author analyses his results in 106 patients after an interval of two years. In 78% the functional result was considered satisfactory, and in 86% the result was anatomically satisfactory.

#### Report on Femoral-Head Prosthesis.

D. E. KING, L. R. STRAUB AND C. N. LAMBERT (*J. Bone Jt Surg.*, July, 1959) have presented the final report of the Committee for the Study of Femoral Head Prostheses of the American Academy of Orthopaedic Surgeons. Two previous surveys have been made. The authors note some important changes in this final report. Four hundred and fifty-three members replied "Yes" to the question "Are you now using femoral head prostheses?". These 453 members of the Academy had performed 10,059 unilateral and 96 bilateral procedures. The numbers of surgeons using the more popular types of prosthesis were: Moore, 195; Thompson, 134; Eicher, 76; Naden-Reith, 19; only four were still using the Judet prosthesis. This was in sharp contrast to the reply to this question in the previous investigation in 1954, when the Judet prosthesis headed the list in popularity, and only 24 surgeons were using the Moore prosthesis. It is noted that there has been an increase in the use of prostheses in the treatment of subcapital fractures of the neck of the femur in patients over 60 to 70 years of

age, and this has now become the most common indication for the use of a hip prosthesis. It is stated that the value of a prosthesis in the treatment of rheumatoid arthritis appears to be in dispute, some surgeons mentioning this condition as an indication for the use of a prosthesis, while others mention it as a contraindication. Statistics are also given on the functional results obtained, on the evaluation of results, on complications, on the types of broken prostheses reported, and on the operative approach.

#### Radiographic Changes in Perthes' Disease.

J. A. O'GARRA (*J. Bone Jt Surg.*, August, 1959) discusses Perthes' disease, and states that patients with this disease can be divided into two groups. The first consists of those with anterior Perthes' disease in whom the lateral radiograph of the hip shows a detectable change early in the progress of the disease. The translucent appearance spreads finally through the whole front of the epiphysis, leaving a peripheral rim of bone. The process of breaking up and reconstruction follows rapidly in children under eight years of age, but seems slower in older children. The second group are those in whom the whole epiphysis is affected by a more rapid progress, flattening, and fragmentation occurring early. Reconstruction in this type is not as rapid as in the first group. The author has obtained good results by treating his patients by traction in bed. A few were treated by weight-relieving calipers and a patten on the other leg. The period of recumbency was from 17 to 27 months. He notes that it is important to follow the changes by X-ray examinations, but stresses that skiagrams need only be taken at four months after the beginning of treatment, then at 10 months, and finally at 16 months. He discusses the prevailing theories as to the cause of this condition and compares it with osteochondritis dissecans and other epiphyseal conditions.

#### Low Back Pain.

C. HIRSCH (*J. Bone Jt Surg.*, May, 1959) reports an extensive series of investigations into the clinical features of low back pain. He attempts to correlate the macroscopic and microscopic anatomical changes in the lumbar discs, together with a comparative study of degeneration in animals with the mechanism of pain. It was found that among 2000 people examined clinically and radiographically in an area of Sweden the incidence of low back pain was 65%. There was no marked increase in incidence among heavy manual labourers except that these people had to stay off work longer. Injury was blamed in about 20% of cases. As a result of his anatomical and histological examinations, the author concludes that degeneration is an avascular change and that rupture and damage are usually the result of mechanical forces. This conclusion was reached because 75% of the damaged discs occurred in the lower two lumbar intersubvertebral spaces. The pain mechanism is considered to come from tension of the posterior ligament over the bulging intersubvertebral disc. The author reports the existence of nerve elements in the posterior longitudinal ligament but

not in the disc. He notes that complete degeneration and abutment of body to body produced stability and relief of pain. He suggests in conclusion that the injection of a chondrolytic enzyme into the disc to transform the degenerate disc into deep dense connective tissue seems a possible means of cure of back pain.

#### Lumbar Spinal Osteotomy.

W. A. LAW (*J. Bone Jt Surg.*, May, 1959) presents a discussion of lumbar spinal osteotomy, based on an experience of over 100 operations, performed at the London Hospital, of which 80 cases were available for review. He briefly reviews the history, discussing the techniques of La Shapell and Smith-Petersen. The reasons for performing the operation on patients suffering from either ankylosing spondylitis or rheumatic spondylitis are: (i) to enable the patient to become erect; (ii) to improve respiration; (iii) to relieve pressure in upper abdominal viscera; (iv) occasionally to allow abdominal surgery. The author uses the method of Smith-Petersen between the second and third lumbar vertebrae or where the calcification of the anterior longitudinal ligament is least, and discusses details of the operation. He points out that it is rarely necessary to divide the ligament in a second stage procedure as described by La Shapell. In the high lumbar spine osteotomy, ileus is common and osteotomy of the thoracic part of the spine is not practicable. The author controls the patient manually, and avoids elaborate apparatus. The patient is usually immobilized after the operation by means of a plaster jacket. In some of the later cases plate fixation was used instead of plaster. Results and complications of the operation are discussed; eight patients (out of 100) died from complications of the operation. These deaths included one case of accidental suffocation because of a rigid cervical segment. This is a hazard, along with the reduced vital capacity, to the operation. There were two patients who developed serious cord lesions and died of bronchopneumonia. The author considers that the danger of these serious complications would be reduced if the operation was performed at an earlier age.

#### Posterior Fusion of the Spine for Scoliosis.

I. W. WINCHESTER (*J. Bone Jt Surg.*, May, 1959) reviews a series of 66 patients who underwent posterior spinal fusion for scoliosis. Scoliosis may be idiopathic, paralytic or congenital. Of these patients 55 were followed for periods of from three to 10 years. This series comprised the operative cases from among 1000 patients treated for scoliosis at the hospital, i.e. 7% of the total. The author notes that Cobb operated on 6% of his patients. The author reviews McRae Aitken's method of correction of scoliosis by serial plaster jackets of the Abbott type, which has been used at the Robert Jones and Agnes Hunt Orthopaedic Hospital for many years. The results revealed that almost all the patients relapsed to a greater or lesser degree. This figure was higher than was expected from clinical examination. All the patients with idiopathic scoliosis relapsed. Two patients with paralytic scoliosis who did not relapse had



been over the age of 20 years when fusion was performed for the relief of pain. Fusion therefore failed to maintain the corrected position of the spine, but it did succeed in holding the uncorrected curve. The curves that had been corrected to the least amount relapsed to the greatest amount. The author notes that the clinical improvement was often better than might be expected from the radiographic assessment of the case, good correction of the visible deformity being achieved even though the anatomical correction was slight.

#### Paralytic Dislocation of the Hip.

E. W. SOMMERVILLE (*J. Bone Jt Surg.*, May, 1959) discusses paralytic dislocation of the hip, the result either of true paralysis of the hip or of postural deformity. The first type is usually associated with a flail hip, and the author describes the mechanism, which consists of the development of coxa valga which brings the line of the neck at right angles to the transverse axis of the pelvis. This puts the hip joint in a favourable position for dislocation. Treatment should be early, and after preliminary reduction of the dislocation on a frame, osteotomy is performed, usually in the upper part of the shaft, where a rotation as well as an adduction osteotomy is possible. The position is carefully assessed pre-operatively and at operation fixation is effected by a plate and screws. Paralytic dislocation which results from postural disturbances occurs because of pelvic obliquity, caused either by factors operating higher up, e.g., in the spine, or by conditions below, such as an adduction flexion deformity of one hip. In the former case it is often the result of paralytic scoliosis, treatment is usually unsatisfactory, and the dislocation is better left untreated. In the latter case, correction is usually by osteotomy unless there is some serious flexion contracture, in which case it is effected by carefully controlled soft tissue resection.

#### PHYSICAL MEDICINE AND REHABILITATION.

##### Bladder Rehabilitation in Spinal Cord Injuries.

W. C. STOLOV (*Arch. phys. Med.*, November, 1959) reviews the results obtained in a series of 59 patients with spinal cord injuries treated in the University of Minnesota Rehabilitation Service during the last four years. Of these 59 patients, 64% are catheter-free. Of those admitted to the service with catheters, 58% were converted to a catheter-free status. Men did slightly better than women. Patients with autonomous bladders had a greater conversion rate (86%) than did those with reflex bladders (63%). Of those with incomplete lesions 74% were converted to catheter-free status, compared with 59% of those with complete lesions. Patients with lesions at the level of the tenth thoracic vertebra and below had a conversion rate of 83%. The average period between injury and the achievement of catheter-freedom was 7.5 months. Conversion to catheter-freedom was achieved in six months by patients with

upper motor neuron lesions, and in three months by those with incomplete lesions. Ischaemic ulcer was the major cause of failure to attain a catheter-free status, and vesical lithiasis was the most frequent urinary-tract complication (30%). The physiology of micturition with respect to the sacral spinal reflex centre is reviewed, and techniques of treatment are discussed. The treatment programme that has been evolved in the care of the cord bladder is presented. In an addendum to the foregoing paper, W. C. Stolorov states that two further patients in the series have been converted to catheter-freedom. In addition, six new patients were admitted to the service, and five achieved catheter-freedom. No attempt at conversion was attempted in the sixth case for adequate reasons. The over-all conversion rate thus becomes 65%, which is broken down to 56% for cervical lesions, 64% for lesions between the first and ninth thoracic levels and 85% for lesions between the tenth thoracic and fifth sacral levels. The average period between injury and catheter-freedom in these additional cases was 6.5 months.

#### Experimental Evaluation of Ultrasonic Effects.

J. F. LEHMANN *et alii* (*Arch. phys. Med.*, November, 1959) present the results of an experimental evaluation of the effects of ultrasound on live pigs comparable in weight to human beings. A maximal therapeutic dose of ultrasonic energy was applied over the areas of surgical metallic implants. Temperature levels measured in the focal area of ultrasonic intensity resulting from reflection at the metal implant surface were within the range generally considered to be therapeutic. Histological studies demonstrated that ultrasound applied in the presence of a surgical metallic implant did not produce any untoward effects. Specifically, there was no evidence of burns, delayed bone and soft-tissue healing or non-thermal reactions such as cavitation. The authors state that these results, obtained in live animals with the blood flow intact, demonstrate that it is possible to apply ultrasonic energy safely in the presence of surgical metallic implants. The therapeutic efficacy of ultrasonic energy in the treatment of joint contractures associated with conditions frequently managed with the insertion of metallic implants remains to be evaluated.

#### Muscle Weakness in Relation to Age and Sex.

T. S. DANOWSKI and M. J. WRATNEY (*Arch. phys. Med.*, December, 1959) have measured the performance of muscles against resistance and gravity in healthy children. They find that there is a relative weakness in the extrapelvic and pelvic groups in boys and girls aged seven to 15 years. Thereafter males attain maximum muscle strength in all groups, whereas a significant proportion of females aged 15 to 30 years manifest a weakness of the hip flexors, hip rotators, hip extensors and gluteus medius. It is suggested, but not established, that these age and sex variations in muscle strength are related to androgen-estrogen secretion. The authors recommend that the presence of such weaknesses in a normal or average

population should be taken into account in tests of muscle performance.

#### Neuro-Surgical Relief of Intention Tremor.

I. S. COOPER (*Arch. phys. Med.*, January, 1960) states that intention tremor may be relieved by chemo-thalamectomy. The lesion produced is in the medial portion of the ventrolateral nucleus of the thalamus. This lesion apparently interrupts nerve fibres entering the thalamus from the globus pallidus, the red nucleus, the cerebellum and probably also the vestibular nucleus. Relief of intention tremor has been maintained for as long as one year, the duration of the study. Moreover, intention tremors of such varying aetiology as familial cerebellar degeneration, severe intracranial trauma, toxic hepato-cerebral disease and multiple sclerosis have been alleviated by the procedure. An illustrative case is presented.

#### "Marsilid" in Chronic Physical Illness.

J. R. HODGE and F. C. SHONTZ (*Arch. phys. Med.*, January, 1960) have carried out a double-blind study of the effects of "Marsilid" (iproniazid) and a placebo upon 13 patients suffering from chronic physical illness accompanied by symptoms of depression, apathy, withdrawal and lack of motivation for rehabilitation procedures. All patients were subjected to psychological tests and psychiatric evaluation during the six weeks period of the study. No significant qualitative or quantitative changes were found in any of the three groups. The authors conclude that "Marsilid" alone in the dosage employed (100 mg. per day), and in the absence of all psycho-therapeutic techniques, was of no significant value in the management of these conditions.

#### Judgement of Vertical and Horizontal in Hemiplegia.

H. G. BIRCH *et alii* (*Arch. phys. Med.*, January, 1960) present the first of a series of reports on perception in hemiplegia, in which they discuss judgement of vertical and horizontal. They state that the results indicate that systematic alterations in visual perception of the vertical and the horizontal occur as important sequelae of the neurological damage that results in hemiplegia. Their results are discussed in terms of their implications for rehabilitation practice and of their significance for neurological and perceptual theory.

#### Crutches in Severe Upper Extremity Impairment.

P. HARBINE, N. STAAEL and J. A. EVERT (*Arch. phys. Med.*, November, 1959) present the design of crutches for a patient with severe impairment of the upper extremity. They state that the use of the crutches may enable the patient to begin gait training at an early phase of rehabilitation. The crutches were designed for a four-point gait, but have proved sufficiently substantial for a swing-through gait. The authors consider that the type of crutch described may be readily adapted for other patients with severe disability of one or both upper extremities.

## British Medical Association.

### NEW SOUTH WALES BRANCH: ANNUAL MEETING.

The annual meeting of the New South Wales Branch of the British Medical Association was held at the Robert H. Todd Assembly Hall, British Medical Association House, 135 Macquarie Street, Sydney, on March 31, 1960, Dr. M. S. ALEXANDER, the President, in the chair.

#### ANNUAL REPORT OF THE COUNCIL.

The annual report of the Council was taken as read and received on the motion of Dr. T. Y. Nelson, seconded by Dr. K. S. Jones. The report was commented on by Dr. Nelson and Dr. Jones. The report was adopted on the motion of Dr. T. Y. Nelson, seconded by Dr. K. S. Jones. The report is as follows.

The Council presents the following report on the work of the Branch for the year ended December 31, 1959.

#### Membership.

The membership of the Branch at December 31, 1959, was 4,310 as against 4,186 at December 31, 1958. The additions included 158 elections, reelections and resumptions, and 128 removals into the area of the Branch; while the losses have included 22 by resignation, 81 removals out of the area of the Branch, 26 by non-payment of subscription and 33 by death. The losses by death were as follows: Dr. M. J. Gillies, Dr. J. Rutherford, Dr. A. D. Forbes, Dr. F. J. McCarthy, Dr. M. R. Coolican, Dr. C. J. Cardamantis, Dr. A. McNeil, Dr. G. B. Smith, Dr. I. A. McLean, Dr. C. E. Fitzgerald, Dr. L. G. Teece, Dr. M. A. Schallit, Dr. G. M. Barron, O.B.E., Dr. W. T. D. Maxwell, Sir Norman Paul, Dr. L. M. Herz, Dr. C. R. M. Lavery, Dr. E. L. Susman, Dr. D. Adcock, Dr. H. H. Lee, Dr. W. L. Rees, Dr. M. W. Phipps, Dr. A. J. Z. G. Pokorny-Zsigmond, Dr. T. W. Hesilton, Dr. S. George, Dr. A. R. Moseley, D.S.O., Dr. I. G. Manning, Dr. A. H. Leitch, Dr. F. J. Graham, M.B.E., Dr. W. P. MacCallum, C.B.E., D.S.O., Dr. N. W. M. Hughes, Dr. A. N. St. G. H. Burkitt, Dr. F. J. Howell.

#### Obituary.

##### *George Moncrieff Barron, O.B.E.*

The death of Dr. George Moncrieff Barron brought to a close a life which had given great service to the community.

A member of the Council of the New South Wales Branch from 1932 to 1946, he occupied the Presidential Chair in 1939.

During his many years in practice at Manly he did outstanding work in connexion with the Far West Children's Health Scheme, for which he will always be remembered.

##### *Colin Robert Moore Lavery.*

Dr. Colin Robert Moore Lavery was one of those members of the profession who, during his professional life, showed a great interest in the well-being of his colleagues.

At one stage in his career he was the President of the Illawarra Suburbs Medical Association. At the time of his death he was in his fifth year as a member of the Council of the New South Wales Branch. During the year 1956-57 he was Honorary Secretary of the Branch.

By his death the profession has suffered a great loss.

##### *Angus McNeil.*

Dr. Angus McNeil joined the staff of the Federal Council of the British Medical Association in Australia as Assistant General Secretary in February, 1957. Prior to accepting this appointment he had practised at Kempsey where he had always interested himself in the affairs of the Eastern District Medical Association. In 1949 he was appointed Honorary Secretary of that Association and also its delegate to the Annual Meeting of Delegates of Local Associations with Council, positions which he occupied until 1956.

In his unexpected and tragic passing the Association suffered a great loss.

#### Congratulations.

Congratulations were extended to Sir Charles Bickerton Blackburn, O.B.E., on the distinguished honour of Knight Commander of the Most Distinguished Order of St. Michael and St. George conferred upon him by Her Majesty the Queen.

Congratulations were also extended to Sir Edward Ford on the occasion of the bestowal of a Knighthood on him, and to Dr. Lindsay A. Dey, C.B.E., Dr. Grace Cuthbert Browne, M.B.E., and Dr. C. G. Harper, M.B.E., on the honours conferred upon them by Her Majesty the Queen.

#### Meetings.

Ten ordinary general meetings of the Branch (including the annual general meeting), three extraordinary general meetings of the Branch and ten clinical meetings were held. The average attendance was 60.

Eight ordinary general meetings were held in conjunction with meetings of the Special Groups, viz.: April 30, with the Section of Paediatrics and the Section of Pathology; May 28, with the Orthopaedic Group (British Medical Association) and the Section of Medicine; June 25, with the Section of Surgery and the Section of Anaesthesia; July 30, with the Section of Occupational Medicine and the Section of Medicine; August 27, with the Section of Radiology and the Section of Occupational Medicine; September 17, with the Section of Obstetrics and Gynaecology; November 26, with the Section of Paediatrics, the Section of Neurology, Psychiatry and Neurosurgery and the Section of Medicine; December 10, with the Section of Allergy and the Dermatological Association of Australia (British Medical Association). Seventeen papers were presented at these meetings. At the meeting held on October 29, two sound films of medico-legal interest entitled "The Doctor Defendant" and "The Medical Witness" were presented through the courtesy of Wm. S. Merrell (Pty.) Ltd.

The ordinary general meeting on Saturday, October 31, was held in the University of Technology, Maitland Road, Islington, Newcastle, it being the eighth meeting of the Branch to be held in the country. There were 49 members present, and two papers were read. A clinical meeting was also held at the Mater Misericordiae Hospital, Waratah, on November 1, and, in addition, social functions were arranged by the Central Northern Medical Association. The Council extends its grateful thanks to the Central Northern Medical Association for its assistance in the organization of these meetings.

At the extraordinary general meeting on May 14 an amendment was made to By-Law 16 (1) (Name Plates), and a new By-Law was adopted, viz. By-Law 24a (Reference of Patients to Persons Other Than Legally Qualified Medical Practitioners). By-Law 4 (Annual Subscription) was amended at the extraordinary general meeting on November 10.

The clinical meetings were held at the Rachel Forster Hospital for Women and Children, Royal North Shore Hospital of Sydney, Royal Prince Alfred Hospital, Royal Alexandra Hospital for Children, Saint Vincent's Hospital, Lewisham Hospital, Sydney Hospital, The Women's Hospital, Crown Street, The Saint George Hospital and the Royal South Sydney Hospital Rehabilitation Centre.

An invitation was extended to the fifth and sixth year medical students of the University of Sydney to attend ordinary general meetings and to sixth year medical students to attend clinical meetings of the Branch.

#### Representatives.

The Branch was represented as follows:

1. Council of the British Medical Association: Professor B. W. Windøyer.
2. New South Wales State Cancer Council: Sir Benjamin Edye, C.B.E.
3. Department of Social Services Standing Departmental Rehabilitation Committee: Dr. M. Naomi Wing.
4. Post-Graduate Committee in Medicine, The University of Sydney: Dr. E. F. Thomson, Dr. K. S. Jones and Dr. S. R. Dawes.
5. Board of Optometrical Registration: Dr. J. Davis.
6. Fluoridation of Public Water Supplies Advisory Committee: Dr. D. G. Hamilton.
7. Annual Representative Meeting, British Medical Association, Edinburgh, July, 1959: Dr. V. M. Coppleson, Dr. J. G. Radford, Dr. H. M. Owen.
8. The Ophthalmic Association Ltd.: Dr. E. V. Waddy Pockley.
9. New South Wales Institute of Dietitians: Dr. F. H. Read.
10. New South Wales Bush Nursing Association: Dr. L. W. Wing.
11. Florence Nightingale Memorial Committee of Australia: Dr. Mary Puckey.

12. Old People's Welfare Council of New South Wales: Dr. G. L. Howe.
13. New South Wales Institute of Hospital Almoners: Dr. R. A. R. Green.
14. New South Wales Association for Mental Health: Dr. A. T. Edwards.
15. Royal Flying Doctor Service of Australia, New South Wales Section: Dr. George Bell, O.B.E.
16. New South Wales College of Nursing: Dr. E. F. Thomson.
17. Hospitals Contribution Fund of New South Wales: Dr. Hugh Hunter.
18. City of Sydney Youth Welfare Advisory Committee: Dr. G. L. Howe.
19. Rehabilitation Coordinating Council of New South Wales: Dr. J. G. Hunter, C.M.G.
20. Committee for the Placement of Resident Medical Officers: Dr. T. Y. Nelson.
21. Federal Council of the British Medical Association in Australia: Dr. A. J. Murray, O.B.E., Dr. W. F. Simmons, Dr. R. H. Macdonald, O.B.E., and Dr. E. F. Thomson.
22. Medical Officers' Relief Fund (Federal), Local Committee of Management for New South Wales: Dr. A. M. McIntosh, Dr. A. J. Murray, O.B.E., and Dr. R. H. Macdonald, O.B.E.
23. Medical Finance Limited, Board of Directors: Dr. E. A. Tivey, Dr. A. C. Thomas, Dr. George Bell, O.B.E., and Dr. G. C. Halliday.
24. Australasian Medical Publishing Co. Ltd.: Dr. W. F. Simmons, Dr. W. L. Calov and Professor L. F. Dods, M.V.O.
25. New South Wales Medical Board: Dr. J. R. Ryan.
26. Federal Medical War Relief Fund, Local Committee of Management: Dr. R. H. Macdonald, O.B.E., Dr. A. C. Thomas and Dr. A. J. Murray, O.B.E.
27. National Association for the Prevention of Tuberculosis in Australia (New South Wales Division): Dr. W. Cotter B. Harvey.
28. Medico-Pharmaceutical Liaison Committee: Dr. D. G. Hamilton, Dr. G. L. Howe, Dr. Mary C. Puckey and Dr. W. F. Simmons.
29. Department of Public Health, Poisons Advisory Committee: Sir William Morrow, D.S.O.
30. Department of Motor Transport (Committee to consider the question of adoption of chemical tests of body fluids to determine whether a driver is under the influence of alcohol): Dr. F. S. Hansman.
31. National Health Service: Pensioner Medical Service Committee of Inquiry: Dr. M. S. Alexander, O.B.E., Dr. B. A. Cook, Sir William Morrow, D.S.O., and Dr. A. C. Thomas.
32. New South Wales Association of Medical Records Librarians Advisory Committee: Dr. T. Y. Nelson.
33. State Medical Planning Committee: Dr. M. S. Alexander, O.B.E.
34. Medical Appointments Advisory Committee: Dr. T. Y. Nelson.
35. New South Wales Examining Council in Medical Technology (Hospitals Commission of New South Wales): Dr. A. K. Sewell and Dr. A. E. Gatenby.
36. St. John Ambulance Association: Dr. M. S. Alexander, O.B.E.
37. Special Departmental Committee for Investigation of Maternal Deaths: Dr. E. A. Tivey. Alternate Representative: Dr. M. H. Elliot-Smith.
38. Coordinating Council of the Physically Handicapped: Dr. R. A. R. Green.
39. Road Safety Council of New South Wales: Dr. M. S. Alexander, O.B.E.
40. Standards Association of Australia: (i) Safety Standards Coordinating Committee, Dr. W. E. George; (ii) Institutional Supplies Committee, Dr. S. W. G. Ratcliff; (iii) Sectional Committee on Interior Illumination of Buildings, Dr. J. Davis; (iv) Committee of Standards of Laboratory Glassware and Volumetric Glassware, Dr. F. S. Hansman; (v) New South Wales Committee on Protective Occupational Clothing, Dr. J. H. Blakemore; (vi) Paint and Varnish Sub-Committee No. 8, Dr. J. H. Blakemore; (vii) New South Wales Committee on Eye Protection, Dr. J. Davis; (viii) Sectional Committee on

Measuring Cups and Spoons, Dr. W. W. Ingram; (ix) New South Wales Committee on Industrial Respiratory Protective Devices, Dr. W. E. George.

#### Council.

(a) The attendance of members of the Council and of the standing committees was as set out in the accompanying table.

(b) The representatives of the Local Associations of members appointed on the invitation of the Council to attend the regular quarterly meetings of the Council were as follow: Dr. A. W. Raymond (Blue Mountains), Dr. M. M. Ramsden (Border), Dr. G. R. Elliott (Brisbane Water District), Dr. A. Rumore (Canterbury-Bankstown), Dr. R. V. Dan (Central Northern), Dr. R. J. Hoy (Central Southern), Dr. G. N. M. Aitkens (Central Western), Dr. H. E. Masters (Eastern District), Dr. F. G. A. Cereche (Eastern Suburbs), Dr. G. P. Charles (Far South Coast and Tablelands), Dr. D. L. Peate (Hunter Valley), Dr. A. F. Hornbrook (Illawarra Suburbs), Dr. N. P. Breden (Kuring-gai District), Dr. P. K. Bell (Nepean Hawkesbury), Dr. J. H. Priestley (Northern District), Dr. T. L. Roberts (North Eastern), Dr. B. A. Brown (Southern District), Dr. P. J. Geddes (South Eastern), Dr. B. S. Courtenay (South Sydney), Dr. Margery Scott-Young (Warringah District), Dr. K. B. Redmond (Western), Dr. S. A. Bonnette (Western Suburbs).

#### Library.

Dr. D. G. Hamilton was appointed to the position of Honorary Librarian.

Visitors to the Library .. .. .	7,799
Books lent to Members .. .. .	1,297
Journals lent to Members .. .. .	5,608
Books added to the Library .. .. .	274
Journals added to the Library .. .. .	4

Despite the fact that a greater number of requests for inter-library loans was received throughout the year, the figure for the number of visitors to the library shows an increase on previous years.

The demand for the use of the photocopying service is increasing, and the purchase of a "Thermofax" copying machine has greatly assisted in supplementing the service already available.

The Council is desirous of conveying its appreciation to the following for donations of periodicals, books, reprints: The Editor, THE MEDICAL JOURNAL OF AUSTRALIA; Abbott Laboratories; Pfizer Proprietary Limited; Dr. A. E. F. Chaffer; Dr. A. H. Tonkin, Medical Association of South Africa, Professor F. J. Browne, New South Wales State Cancer Council; Lieut.-General Sir A. Drummond, K.B.E., C.B.; Repatriation Commission; Australian Dental Association; Dr. Louis Bauer, World Medical Association; St. George Hospital; Dr. J. F. C. C. Cobley; Dr. A. L. Lance; Dr. J. H. Halliday; Blood Transfusion Service; Dr. H. J. Eisenberg; Dr. D. T. Shortridge; Consul General for France; Dr. J. C. Bellisario; Dr. T. G. Hungerford; Imperial Chemical Industries; Dr. P. M. Corlette; Dr. M. A. Egan; Dr. S. L. Spencer; Professor W. S. Dawson; National Kidney Disease Foundation, New York; Australian Advisory Council for the Physically Handicapped; Commonwealth of Australia, Department of Supply; Dr. Collin M. Edwards; Mrs. C. A. Butcher, on behalf of the late Dr. C. L. Gabriel; Dr. J. K. Maddox; United States Information Service; Mrs. E. M. C. Friedlander, on behalf of the late Dr. Friedlander; Dr. Alexander Owen; Dr. Margaret Mulvey; Dr. I. Douglas Miller; University of Melbourne; Royal Melbourne Hospital; Mr. Eric Hilder, New South Wales Medical Board; Alfred Hospital, Melbourne; Australian Red Cross Society, New South Wales Branch; Dr. K. E. Shellshear; United Kingdom Information Office; Medical and Chirurgical Faculty of the State of Maryland Library; American College of Surgeons; Vanderbilt University School of Medicine Library, Tennessee; Queensland Institute of Medical Research; Post-Graduate Committee in Medicine, University of Sydney; National Nephrosis Foundation Incorporated; College of Radiologists (Australia and New Zealand); Dermatological Association of Australia (B.M.A.); Oto-laryngological Society of Australia, New South Wales Section (B.M.A.); Section of Medicine; Section of Obstetrics and Gynaecology.

#### Affiliated Local Associations of Members.

Blue Mountains (affiliated 1944): *Chairman*, Dr. T. Lesslie; *Honorary Secretary*, Dr. N. Larkins. Membership 28.

Border (affiliated 1908): *Honorary Secretary*, Dr. R. S. Hayter. Membership 24.



## ATTENDANCE AT COUNCIL AND STANDING COMMITTEE MEETINGS, JANUARY 1, 1959, TO MARCH 19, 1959.

	Council.	Committees.					
		Executive and Finance.	Organization and Science.	Medical Politics.	Hospitals.	Ethics.	Public Relations.
ALEXANDER, M. S. President-Elect ..	3	3	1	3	—	1	1
BOOTH, E. A. ..	3	—	1	—	—	—	—
BROWN, D. A. ..	2	—	—	—	—	—	1
COBLEY, J. F. C. C. ..	2	—	1	—	1	—	—
COOK, B. A. ..	3	—	1	—	1	—	—
HAMILTON, D. G. ..	3	—	—	—	1	—	—
HOWE, G. L. Past President ..	2	3	—	—	1	—	—
JONES, K. S. ..	3	—	—	2	—	—	1
KENNY, P. J. ..	1	—	—	—	—	—	—
LAVERY, C. R. M. ..	3	2	—	—	—	—	—
MACDONALD, R. H. ..	3	3	—	—	—	1	—
MONAHAN, B. W. ..	3	—	—	3	—	—	—
MORROW, SIR WILLIAM. President ..	3	3	—	—	—	1	—
MURRAY, A. J. ..	3	3	—	—	—	—	—
NELSON, T. Y. Honorary Secretary ..	3	3	1	3	1	1	1
PUCKEY, MARY C. ..	3	—	1	—	1	—	—
RAWLE, K. C. T. ..	3	—	—	—	1	—	—
SIMMONS, W. F. Honorary Treasurer <sup>1</sup> ..	2	2	—	1	1	—	1
SPEIGHT, R. J. J. ..	2	—	—	2	—	—	—
STUCKEY, E. S. ..	3	—	—	3	—	1	—
THOMSON, E. F. ..	3	2	—	—	—	—	—
TOMLINSON, P. A. ..	3	—	—	—	1	—	—
WARDEN, D. A. ..	3	—	—	2	—	—	—
WING, L. W. ..	3	—	1	3	—	—	—
Meetings held ..	3	3	1	3	1	1	1

<sup>1</sup> Leave of absence—1 month from January 1, 1959.

Brisbane Water District (affiliated 1948): *Chairman*, Dr. A. B. Paul; *Honorary Secretary*, Dr. J. K. Fullagar. Membership 28. Five meetings were held.

Broken Hill (affiliated 1942): *Honorary Secretary*, Dr. Franziska Schlink.

Canterbury-Bankstown (affiliated 1930): *Chairman*, Dr. H. Abramovich; *Honorary Secretary*, Dr. A. Rumore. Membership 95. Four meetings were held.

Central Northern (affiliated 1910): *Chairman*, Dr. L. A. Dawson; *Honorary Secretary*, Dr. R. V. Dan. Membership 133.

Central Southern (affiliated 1909): *Chairman*, Dr. J. A. Holt; *Honorary Secretary*, Dr. D. C. Henchman. Membership 74. Two meetings were held.

Central Western (affiliated 1910): *Chairman*, Dr. J. Sheehy; *Honorary Secretary*, Dr. L. P. H. Jeffery. Membership 75.

Eastern District (affiliated 1913): *Chairman*, Dr. I. Barrie; *Honorary Secretary*, Dr. H. E. Masters. Membership 44. Two meetings were held.

Eastern Suburbs (affiliated 1911): *Chairman*, Dr. P. D. Hipsley; *Honorary Secretary*, Dr. G. R. Faithfull. Membership 172. Six meetings were held.

Far South Coast and Tablelands (affiliated 1935): *Chairman*, Dr. J. McKee; *Honorary Secretary*, Dr. G. P. Charles. Membership 30. Two meetings were held.

Hunter Valley (affiliated 1947): *Chairman*, Dr. A. J. R. Clarke; *Honorary Secretary*, Dr. I. F. Waugh. Membership 54. Five meetings were held.

Illawarra Suburbs (affiliated 1913): *Chairman*, Dr. E. F. Ellis; *Honorary Secretary*, Dr. K. W. Alexander (January 1–September 7, 1959), Dr. A. F. Hornbrook (September 7–December 31, 1959). Membership 163. Three meetings were held.

Kuring-gal District (affiliated 1929): *Chairman*, Dr. P. H. Doyle; *Honorary Secretary*, Dr. R. B. Geeves. Membership 137. Four meetings were held.

Nepean Hawkesbury (affiliated 1957): *Chairman*, Dr. W. F. J. Cammack; *Honorary Secretary*, Dr. J. J. Bain. Membership 19.

Northern District (affiliated 1911): *Chairman*, Dr. D. C. Howie; *Honorary Secretary*, Dr. J. H. Priestley. Membership 90.

North Eastern (affiliated 1913): *Chairman*, Dr. N. E. Brand; *Honorary Secretary*, Dr. N. J. Rogers. Membership 67. Three meetings were held.

South Eastern (affiliated 1914): *Chairman*, Dr. H. G. Rich; *Honorary Secretary*, Dr. P. J. Geddes. Membership 77.

Southern District (affiliated 1909): *Chairman*, Dr. J. F. Ziegler; *Honorary Secretary*, Dr. B. A. Brown. Membership 24. Four meetings were held.

South Sydney (affiliated 1909): *Chairman*, Dr. B. Courtenay; *Honorary Secretary*, Dr. A. R. G. Gordon. Membership 16.

Warringah District (affiliated 1929): *Chairman*, Dr. D. C. Williams; *Honorary Secretary*, Dr. P. Cambourn. Membership 216. Five meetings were held.

Western (affiliated 1908): *Chairman*, Dr. T. C. Meurer; *Honorary Secretary*, Dr. S. R. Dawes. Membership 115. Three meetings were held.

Western Suburbs (affiliated 1908): *Chairman*, Dr. S. A. Bonnette; *Honorary Secretary*, Dr. Warren Smith. Membership 144. Three meetings were held.

## Annual Meeting of Delegates.

The forty-sixth annual meeting of delegates of the affiliated associations of members with the Council was held on Friday, October 2, 1959.

The delegates present at the meeting were as follows: Blue Mountains, Dr. A. W. Raymond; Border, Dr. M. M. Ramsden; Brisbane Water District, Dr. G. R. Elliott; Canterbury-Bankstown, Dr. L. Abramovich; Central Northern, Dr. J. Muller; Central Southern, Dr. R. Hoy; Central Western, Dr. G. N. M. Aitkens; Eastern District, Dr. R. B. Vickery; Eastern Suburbs, Dr. J. G. Watson; Hunter Valley, Dr. D. L. Peate; Illawarra Suburbs, Dr. H. Goodman; Kuring-gal District, Dr. C. Warburton; Nepean Hawkesbury, Dr. P. K. Bell; Northern District, Dr. J. H. Priestley; North Eastern, Dr. T. Roberts; Southern District, Dr. B. A. Brown; South Eastern, Dr. A. E. Khan; Warringah District, Dr. Margery Scott-Young; Western, Dr. G. B. Downes; Western Suburbs, Dr. S. A. Bonnette.

## Special Groups for the Study of Special Branches of Medical Knowledge.

Allergy (inaugurated 1947): *Chairman*, Dr. L. E. Hewitt; *Honorary Secretary*, Dr. D. O. Cross. Membership 19. Six meetings were held, one in conjunction with a meeting of the Branch.

Anæsthesia (inaugurated 1934): *Chairman*, Dr. N. W. Bartrop; *Honorary Secretary*, Dr. B. J. Pollard. Membership 101. Five meetings were held, one in conjunction with a meeting of the Branch.

Medicine (inaugurated 1924): *Chairman*, Dr. K. S. Harrison; *Honorary Secretary*, Dr. L. C. A. Watson. Membership 82. Three meetings were held in conjunction with meetings of the Branch.

Neurology, Psychiatry and Neurosurgery (inaugurated 1924): *Chairman*, Dr. A. T. Edwards; *Honorary Secretary*,

## ATTENDANCE AT COUNCIL AND STANDING COMMITTEE MEETINGS, MARCH 19, 1959, TO DECEMBER 31, 1959.

	Council.	Committees.					
		Executive and Finance.	Organization and Science.	Medical Politics.	Hospitals.	Ethics.	Public Relations.
ALEXANDER, K. W. <sup>1</sup>	4	9	—	6	—	—	—
ALEXANDER, M. S. President	5	—	3	6	6	4	4
BOOTH, E. A.	6	—	2	—	—	—	5
BROWN, D. A. <sup>2</sup>	3	—	—	3	—	—	6
CALOV, W. L.	5	—	—	—	5	—	—
COBLEY, J. F. C. C.	5	—	2	—	5	2	—
COOK, B. A. President-Elect <sup>3</sup>	6	4	4	3	5	3	1
HAMILTON, D. G.	5	6	4	—	—	—	—
HOWE, G. L.	5	7	—	4	—	—	—
JONES, K. S.	6	5	—	9	—	5	—
LAVERY, C. R. M. <sup>4</sup>	1	2	—	—	—	2	—
MACDONALD, R. H.	6	9	—	—	—	6	—
MCGUINNESS, A. E.	5	—	2	—	3	—	—
MONAHAN, B. W.	6	—	—	9	—	—	—
MORROW, SIR WILLIAM	3	3	—	—	—	—	—
MURRAY, A. J.	6	9	—	—	—	4	—
NELSON, T. Y. Honorary Secretary	6	9	3	7	5	3	4
PUCKEY, MARY C.	5	—	4	—	6	—	—
RAWLE, K. C. T.	3	—	—	—	5	—	—
SIMMONS, W. F. Honorary Treasurer	6	8	3	8	5	—	4
STUCKEY, E. S.	6	8	—	8	—	—	—
THOMSON, E. F.	5	—	—	—	—	—	5
TOMLINSON, P. A.	4	—	—	—	4	4	—
WARDEN, D. A.	5	—	—	—	—	—	—
WING, L. W.	6	—	—	7	—	—	—
Meetings held .. ..	6	9	4	9	6	6	6

<sup>1</sup> Dr. K. W. Alexander appointed Council July 7, 1959.<sup>2</sup> Leave of absence July 6 to August 10, 1959.<sup>3</sup> Leave of absence December 11, 1959, to March 1, 1960.<sup>4</sup> Died June 5, 1959.

Dr. C. Radeski. Membership 103. Nine meetings were held, one in conjunction with a meeting of the Branch.

Obstetrics and Gynaecology (inaugurated 1925): *Chairman*, Dr. A. S. B. Studdy; *Honorary Secretary*, Dr. D. H. McGrath. Membership 100. Three meetings were held, one in conjunction with a meeting of the Branch.

Occupational Medicine (inaugurated 1952): *Chairman*, Dr. R. T. C. Hughes; *Honorary Secretary*, Dr. W. P. Nelson. Membership 26. Six meetings were held, two in conjunction with meetings of the Branch.

Orthopaedic Group (British Medical Association) (inaugurated 1923): *Chairman*, Dr. A. I. Rhydderch; *Honorary Secretary*, Dr. R. W. D. Middleton. Membership 44. Six meetings were held, one in conjunction with a meeting of the Branch.

The Oto-Laryngological Society of Australia, New South Wales Section (inaugurated 1924): *Chairman*, Dr. F. F. Ellis; *Honorary Secretary*, Dr. B. P. Scrivener. Membership 56. Seven meetings were held.

Pædiatrics (inaugurated 1924): *Chairman*, Dr. S. E. J. Robertson; *Honorary Secretary*, Dr. J. D. McDonald. Membership 105. Two meetings were held in conjunction with meetings of the Branch.

Pathology (inaugurated 1924): *Chairman*, Dr. A. A. Palmer; *Honorary Secretary*, Dr. K. Viner Smith. Membership 99. Five meetings were held, one in conjunction with a meeting of the Branch.

Radiology (inaugurated 1926): *Chairman*, Dr. H. G. Benson; *Honorary Secretary*, Dr. B. E. Frecker. Membership 119. Seven meetings were held, one in conjunction with a meeting of the Branch.

Surgery (inaugurated 1925): *Chairman*, Dr. J. Steigrad; *Honorary Secretary*, Dr. T. E. Wilson. Membership 44. One meeting was held in conjunction with a meeting of the Branch.

Urology (inaugurated 1940): *Chairman*, Dr. M. S. S. Earlam; *Honorary Secretary*, Dr. H. G. Cummine. Membership 11.

#### Federal Council of the British Medical Association in Australia.

The Federal Council met on March 21, 22, 23, 26 and 27, 1959, and September 26, 27, 28 and 29, 1959.

The Branch was represented at both meetings by Dr. A. J. Murray, O.B.E., Dr. W. F. Simmons, Dr. R. H. Macdonald, O.B.E., and Dr. E. F. Thomson.

#### World Medical Association.

In March, 1959, the Council of the World Medical Association held its 36th Session in Sydney.

The New South Wales Branch made available to the Council of the World Medical Association the Robert H. Todd Assembly Hall, the Council Rooms and office accommodation.

The Council of the Branch entertained visitors at dinner at the University Club on April 2, 1959, whilst individual members of Council and of the Association also extended their hospitality.

A letter was received from the Secretary-General of the World Medical Association on behalf of its Council conveying thanks for and appreciation of the hospitality afforded during the holding of the meeting, and for the assistance rendered by Dr. J. G. Hunter, Miss H. Cameron and Miss M. Rolleston in the organization of the 36th Session.

#### Australian Medical Association.

At its last meeting on September 26, 1959, the Federal Council proposed the following resolutions:

- (i) That in the opinion of the Federal Council the time is now opportune to proceed with the formation of an Australian Medical Association independent of but affiliated with the British Medical Association.
- (ii) That the opinion of the Federal Council be forwarded to the Branches with a request that the views of members be obtained.

In order to obtain the opinion of members the matter was referred to all Local Associations and Special Groups.

The proposal has had the general approval of these bodies with very minor qualifications.

The Council advised the Federal Council of the approval of the New South Wales Branch.

#### Secretariat.

On August 13, 1959, the Council appointed Dr. Nicholas Larkins Assistant Medical Secretary of the New South Wales Branch of the British Medical Association.

Dr. Larkins graduated M.B., B.S. (University of Sydney), in 1938. After war service with the Royal Australian Navy Dr. Larkins commenced practice at Katoomba in 1946 and continued to do so until just prior to joining the staff of the Association at the end of September, 1959. Dr. Larkins was Honorary Secretary of the Blue Mountains Medical Association from 1946 till 1959.

### By-Laws.

At an extraordinary general meeting of the Branch held on May 14, 1959, By-Law 16 (i) was amended to read:

"16 (i). No member, except with the approval of the Council conveyed to him in writing, shall have his name-plate affixed elsewhere than:

- (a) at his residence
- (b) at premises where he attends regularly for the purpose of receiving his patients in the ordinary course of his practice.

Provided that except with the approval of the Council conveyed to him in writing no member shall have his name-plate at more than three places."

The By-Law was amended by the deletion of the word "two" before the word "places" and the substitution in lieu thereof of the word "three".

At the same meeting the following new By-Law was adopted: "24b. (a) No member shall undertake any obligation to refer patients to a single optical firm to the exclusion of others.

(b) No member shall attend patients at the premises of an optometrist or optician except with the express sanction of the Council.

(c) No member shall receive commission from a share of profits with an optometrist or optician."

At an extraordinary general meeting of the Branch held on November 10, 1959, By-Law 4 was amended to read:

#### By-Law 4. Annual Subscription.

4. Until otherwise provided the annual subscription of Members of the Association shall be Thirteen Pounds Thirteen Shillings. Provided as follows:

- (a) In the case of a Member admitted to membership during the calendar year in which he shall first become registered as a legally qualified medical practitioner the annual subscription for such year shall be Six Pounds Six Shillings instead of Thirteen Pounds Thirteen Shillings.
- (b) The annual subscription of a Member admitted to membership on or after the first day of July in any year shall for that year be one-half of the annual subscription which would otherwise be payable by him for that year.
- (c) A Member who is over seventy years of age or who shall have permanently retired from medical practice either in an official or any other capacity, shall pay an annual subscription of Four Pounds Four Shillings instead of Thirteen Pounds Thirteen Shillings.
- (d) A Member who shall have been registered as a legally qualified medical practitioner and who is a permanent whole-time member of the Public Service of the Commonwealth of Australia (including the Defence Services) or of the State of New South Wales (including the New South Wales Government Railways and the University of Sydney) or who is a whole-time member of the staff of a Public Hospital or who is engaged in practice solely as an employee of any authority, corporation, company, association or body shall pay an annual subscription of Eleven Pounds Eleven Shillings instead of Thirteen Pounds Thirteen Shillings provided that where such a Member has the right of private practice and exercises that right the subscription payable by him shall be Thirteen Pounds Thirteen Shillings, and provided that a Member who is engaged in practice as a member or an employee or on behalf of a limited liability company which provides or supplies medical, surgical or allied services to the public in a manner similar to a medical practitioner engaged in private practice on his own account shall pay an annual subscription of Thirteen Pounds Thirteen Shillings.
- (e) In the case of two Members being husband and wife residing together, their joint annual subscription shall be Two Pounds Two Shillings less than the total of the respective annual subscriptions which would be payable by them if paid separately.
- (f) A person who shall have been a Member of the Association for a period of fifty years shall not be required to pay any annual subscription as from the first day of January next succeeding the expiration of such period.
- (g) Any member whose financial position is such that he is unable to pay the full annual subscription may

apply to the Honorary Treasurer for a reduction in the rate of subscription; and each case will be considered on its merits subject to the following conditions:

- (i) Satisfactory proof of the said member's inability to pay the full subscription must be brought before the Honorary Treasurer, who will bring the matter before the Executive and Finance Committee, and any information given for this purpose shall be regarded as confidential. The Executive and Finance Committee, if satisfied of the said member's inability to pay the full subscription, shall be empowered to reduce the subscription otherwise payable by the member.
- (ii) Any reduction in the rate of subscription to any member under this rule shall be for a period of one year. If the said member wishes to be granted a reduction in the rate of subscription in any subsequent year he must re-apply to the Honorary Treasurer for such reduction, and such re-application shall be considered by the Executive and Finance Committee as in (i) above.

Provided further that in cases where a Member paying a subscription at one of the beforementioned rates becomes entitled to have his subscription reduced to another of the beforementioned rates the reduction shall apply only from the first day of January next after he shall have given notice to the Association of the happening of the event or the change in his position which entitles him to have his subscription reduced, and until that date he shall continue to pay his subscription at the rate which would be payable by him if such event had not happened or his position had not changed.

#### Annual Branch Prize for an Essay on a Scientific Subject.

The subject for the Annual Branch Prize for the year 1959 was "Disordered Uterine Action".

At the end of the year a final determination of the successful author had not been made. However, prior to the completion of the report an award was made to Dr. W. J. Garrett.

The subject for the year 1960 is "The Problem of the Staphylococcus".

#### Superannuation Scheme for Members of the Profession in Private Practice.

During the year Council decided that a superannuation scheme should be established for members of the profession in private practice.

It is expected that the scheme will be in operation prior to the end of the financial year (June 30, 1960).

#### National Health Act.

During the year consideration was given to a number of aspects of the National Health Service.

In particular the following matters called for a good deal of consideration.

##### Special Accounts.

Under an amendment to the *National Health Act*, Medical and Hospital Benefit Funds were called upon to compulsorily transfer to "Special Accounts" all those contributors over the age of 65 years and, at the discretion of the Fund, those persons suffering from a pre-existing or chronic illness. Hospital benefits for special account contributors could only be paid in respect of "recognized hospitals" resulting in many cases of injustice.

The Council found it necessary to recommend to Federal Council that it protest strongly to the Government against contributors to the Funds over 65 years of age, suffering from acute illnesses, being deprived of the hospital benefits for which they are insured, when admitted of necessity to hospitals not recognized for Fund benefits.

Under legislation enacted during 1959 the definition of "recognized hospital" was so amended as to provide for a more liberal interpretation.

As far as medical benefits are concerned, contributors over 65 years of age need not be transferred.

The amended legislation took effect as from January 1, 1960.

##### Pharmaceutical Benefits.

The Government's proposal to extend pharmaceutical benefits was referred to all Local Associations.

Council advised Local Associations that members of Council would be prepared to visit the Local Associations to



discuss the matter if it was so desired. This invitation was accepted in a number of cases.

In view of the fact that the Government was unable to give Federal Council details of the proposed extended benefits it was difficult for members of the profession to form an opinion on the proposals. Much dissatisfaction exists by reason of the Commonwealth Government's failure to consult the profession and lack of information regarding the scope of the benefits. The Council will advise members of further developments.

#### Pharmaceutical Benefits Booklet.

A number of suggestions to improve the Pharmaceutical Benefits booklet were forwarded to the Federal Council and were subsequently transmitted with some slight amendments to the Minister for Health. The Minister replied thanking the Federal Council for the constructive manner in which it had approached the matter and for the suggestions it had made.

The Minister further indicated the manner in which the booklet would be improved in the future and stated that special steps would be taken to see that all advices to doctors would be posted at exactly the same time as advices to chemists.

#### Benefits for Domiciliary Nurses.

The Royal Australian Nursing Federation sought the support of Federal Council to a proposal that the *National Health Act* should be amended to provide that patients nursed in their own homes by general nurses might claim benefits on their fees.

Council recommended to Federal Council that it should support the proposal.

#### Hospital Policy.

##### Staffing of Country Hospitals (Including Base Hospitals).

At its meeting on January 13, 1959, the Council decided as follows in regard to a policy for the staffing of country hospitals, viz.:

"In establishing a policy for country hospitals (including base hospitals), the following facts must be kept in mind:

1. The realization that base hospitals should be able to provide a better service than smaller country hospitals in such directions as—

- (a) higher standards of practice, to provide a consulting service for the area surrounding the base,
- (b) facilities for training members of the staff,
- (c) facilities for training resident medical officers.

2. As Council realizes the importance of practitioners maintaining contact with their own patients whilst in hospital, it suggests that this may best be effected by a grouping of practitioners in their private practices.

3. The implementation of any system of hospital staffing is dependent on a ready cooperation of the practitioners with the hospital board in making their hospital and their private practice rosters coincide. The full implementation of this policy will be a gradual process depending on such factors as the size of the community and the availability of more specialists and more practitioners holding higher degrees.

4. In determining seniority in a hospital, senior qualifications should be the determining factor if all other factors are equal. It cannot be expected that a recently arrived practitioner with a higher degree should displace one who is already a senior honorary on the staff of the hospital.

5. It is desirable that the stimulus for classification of staffs should come from the honorary medical staff of a hospital when such hospital attains sufficient size and facilities.

With these basic factors in mind, the following is the present policy of the Council:

1. In all country hospitals the Council supports the principle of a visiting staff as opposed to a whole-time salaried staff.

2. The Council recommends the grading of staffs into senior and junior positions and junior members should work with seniors as members of a team.

3. Only senior staff members should have an admitting week in respect of cases not referred by members of the staff.

4. A. (i) Base hospitals should be staffed by classified staffs, i.e., honorary physicians, honorary surgeons, etc., and honorary medical officers.

(ii) Practitioners holding higher qualifications or who qualify by seniority and experience should be appointed to the positions of honorary physician, honorary surgeon, etc.

(iii) Members of the staff not holding the above qualifications should be graded as honorary medical officers.

B. (i) In country hospitals other than base hospitals staffing should be on a general practitioner basis and practitioners should be appointed to the position of honorary medical officer or assistant honorary medical officer.

(ii) As men with higher qualifications become available they should be given the opportunity of appointment as honorary physician, honorary surgeon, etc., to form the commencement of a classified staff.

(iii) Wherever possible the services of consultants should be made available by appointing them to the staff as consultants."

Copies of the policy were forwarded to the various Colleges for their consideration and replies were received as follows:

(a) *The Royal Australasian College of Physicians—Opinion of State Committee:*

"That the State Committee approves of the British Medical Association's policy in toto."

(b) *Royal Australasian College of Surgeons:*

"The Royal Australasian College of Surgeons advised that its Council had considered the policy of the Branch in regard to the staffing of country hospitals which had been referred to it by the New South Wales State Committee of the College.

The Council of the College had no comments to offer concerning the report and policy as it was felt that the matter purely affected New South Wales. Its Council realized that conditions vary in the different States."

(c) *The College of Radiologists of Australasia, New South Wales Branch—Opinion of its Committee:*

"This Committee has no criticism to make of the principles laid down in regard to staffing of country hospitals in so far as they affect radiologists."

(d) *The College of Pathologists of Australia—Opinion of its Council:*

"The Council noted in this statement of policy there was no special reference to pathology services. It was not felt that it was the province of the College of Pathologists of Australia to offer comments on matters outside this sphere."

#### Delegation from Staffs of Country, Base (and Other) Hospitals.

A delegation of members representing the honorary medical staffs of 12 country hospitals had a conference with the Hospitals Committee of Council on August 25, 1959, and on the following day, accompanied by representatives of Council, with the Hospitals Commission of New South Wales.

Amongst the subjects discussed were:

(a) The appointment of medical superintendents of hospitals. This matter arose as a result of a circular from the Hospitals Commission of New South Wales to hospitals in regard to the appointment of medical superintendents. The main issues were (i) the right of the superintendent to admit and discharge patients, and (ii) superintendents being required to have "the ability and fullest authority in exceptional or emergent circumstances to interpose in the treatment and care of any patient". Assurances satisfactory to the Council were received from the Hospitals Commission in regard to these matters.

(b) The problem of obtaining resident medical officers in country hospitals. This has been a difficult matter for some time. The allocation of resident medical officer appointments is made in accordance with the order of merit list of the final degree examination and the graduate's wishes. In extremely few cases do graduates express a wish to be allocated to a country hospital. Consideration was given to certain possibilities in connexion with this matter, such as the securing of resident medical officers from city hospitals for short periods, and the provision of better salaries and married quarters.

(c) The classification of honorary medical officers in country hospitals. The delegation submitted to Council and the Hospitals Commission that classification of honorary medical officers should be only in respect of patients sent in by medical practitioners not on the staff of the hospital.

### Accreditation of Hospitals.

During the year the Council decided to sponsor a committee to draw up a scheme of accreditation of hospitals, based on the accreditation scheme in the United States of America.

In addition to the New South Wales Branch of the British Medical Association with two representatives, it was decided to extend invitations to the following bodies to appoint a representative: The Australian Hospitals Association; The Royal Australasian College of Physicians; the Royal Australasian College of Surgeons; the Royal College of Obstetricians and Gynaecologists, New South Wales Committee; the College of General Practitioners, New South Wales Faculty; The Post-Graduate Committee in Medicine, The University of Sydney; and The Hospitals Commission of New South Wales.

The Hospitals Commission of New South Wales was unable to accept the invitation, but all other bodies accepted.

The first meeting of the Committee was scheduled for February 8, 1960.

### Medical Practitioners' Act.

During the year a recommendation was made to the Director General of Public Health that the *Medical Practitioners' Act* be amended in regard to the following:

#### Section 17 (3)—Registration.

This section provides that where a person is registered under the section he shall not practise his profession until he has served as a medical officer in one or more hospitals or institutions approved by the Board for a period of 12 months or periods amounting in the aggregate to 12 months.

The Council recommended that registration following graduation should be conditional in the first place, and that full registration should be given when the practitioner produces proof of having served for a period of 12 months or periods amounting in the aggregate to 12 months as a medical officer in one or more hospitals or institutions approved by the New South Wales Medical Board.

#### Section 27—Body to which Complaints Should be Made.

This section provides for complaints or charges of a certain nature to be referred to the Board of Health which shall cause the same to be investigated.

It was the opinion of the Council that the Board of Health was not the body to which complaints should be made, and it recommended that provision should be made in the Act for investigation of complaints against members of the profession to be carried out by the New South Wales Medical Board.

It was also recommended that under this section of the Act provision should be made to ensure that a court before which any registered person is convicted of a felony or misdemeanour shall forward particulars of the conviction to the Board of Health in accordance with the provisions of Section 27 (1) of the *Medical Practitioners' Act*, or to such other body as may replace the Board of Health as the body to which complaints against members of the profession should be referred.

#### Section 28 (1)—Disciplinary Tribunal.

Council recommended that the *Medical Practitioners' Act* should be amended to provide that the Disciplinary Tribunal should consist of three (3) persons, a member of the legal profession and two medical practitioners, one appointed by the Minister and one appointed on the recommendation of the New South Wales Branch of the British Medical Association.

#### Costs of Action.

It was recommended that provision should be made under the *Medical Practitioners' Act* for costs to be awarded a doctor when he is exonerated of a charge.

#### Charges—Under Section 27.

It was recommended that consideration should be given to amending the Act to provide that a fee of £5 should accompany any charge against a doctor similar to the provisions of the *Nurses' Registration Act*.

#### Section 34—Medical Practitioners' Charges Committee.

Council recommended that the responsibilities attached to the determination as to whether a doctor's account is

reasonable should be undertaken by the Medical Board and not by a body such as the present Medical Practitioners' Charges Committee.

### Committee on Medical Education.

During the year the Committee on Medical Education undertook the investigation of the bed requirements for teaching purposes.

It is hoped to publish a report on this matter in the early part of 1960.

### Department of Public Relations.

During the year the Department continued to supply the country and suburban Press with articles on "Keeping Your Family Healthy".

The work of popular education has also been maintained by means of radio talks over the National Stations.

Advice was also given to the Press on various medical matters.

### Therapeutics Subcommittee.

With a view to informing members of the dangers associated with new drugs a Therapeutics Subcommittee of Council was formed. The first articles on Phenylbutazone and the Phenothiazines appeared in a supplement to the *Monthly Bulletin* of November 16, 1959.

### Court Witnesses' Fees.

Conferences were held during the year between representatives of the Council and representatives of the Incorporated Law Institute in regard to the fees payable to doctors in respect of evidence given in court.

The Incorporated Law Institute pointed out that the full amounts charged by doctors in respect of evidence given had not been allowed by the taxing officer of the court. The amount allowed was often very small in comparison with the amount charged, resulting in the party concerned being forced to pay an amount which he should not have had to bear.

The Incorporated Law Institute also raised the question of the liability for doctors' fees in such circumstances, and a joint statement in this connexion was drawn up and submitted to members of both professions.

The matter of the amount of the fees payable is still under discussion.

### Industrial Medical Officers.

In 1952 Council laid down certain rates of remuneration which it considered should apply to full-time industrial medical officers.

During the year the Council considered that these rates should be amended and accordingly it decided as follows.

1. A whole-time industrial medical officer who has had three years' experience in the practice of his profession after obtaining a registerable qualification should receive, when first appointed, a starting salary within the range of £2,500-£3,000 per annum, according to the degree of responsibility entailed by the appointment; provided that—

(a) a whole-time industrial medical officer who holds a higher professional qualification or has had special post-graduate training in industrial medicine or more than three years' professional experience, should receive, when first appointed, a starting salary at a suitable incremental point above the minimum which would otherwise be appropriate;

(b) a whole-time industrial medical officer in charge should receive, when first appointed, a starting salary not less than £3,000 per annum.

2. The starting salary should be increased by regular annual increments, each increment being not less than 7½ per cent. of the existing salary.

3. The annual increments should be continued until the salary reaches a maximum normally within the range of £3,000 to £4,500; provided that a maximum salary in excess of £4,500 should be paid when the appointment entails exceptional responsibilities.

4. The introduction of this salary scale should in no circumstances result in the reduction of the existing salary of any industrial medical officer already appointed.

**Balance Sheet as at December 31, 1959.**

M. S. ALEXANDER, President.  
W. F. SIMMONS, Hon. Treasurer.  
J. F. WALKER, Accountant.

We have examined the foregoing Balance Sheet with the Books of Account of the New South Wales Branch of the British Medical Association, and having obtained all the information and explanations we have required, we are of the opinion that such Balance Sheet is properly drawn up so as to exhibit a true and correct view of the state of the Company's affairs according to the best of our information and the explanations given to us and as shown by the Books of the Company. In our opinion, the Register of Members and other records which the Company is required to keep by the New South Wales Companies Act, 1936, or by its Articles have been properly kept.

Registered under the Public Accountants Registration Act, 1945, as amended

Sydney,  
February 12, 1960.

It is to be noted that the description "Medical Officer in Charge" refers to the medical officer who has charge of the medical services of a firm or (in the case of a large firm) of one of its constituent units.

**Child Welfare Department: Attendance on Inmates of Institutions of the Department.**

Information obtained by Council indicated that there was a great variation in the fees payable to medical practitioners rendering services to inmates of institutions controlled by the Child Welfare Department.

The matter was taken up with the Department and the following scale of fees submitted as being reasonable charges.

(a) Payment should be on a concessional basis where more than one patient is seen.

(b) Routine visits in which a number of children are seen, should be paid on a sessional basis of £3 3s. for the first hour or part thereof, plus £1 1s. for each additional half hour or part thereof. Mileage, where applicable, to be extra.

(c) Special Visits:

(i) To Surgery—

First patient .. .. .	£1 0 0
Each subsequent patient .. .. .	12 6

(11) To Home—

First patient .. .. .	£1 5 0
Each subsequent patient .. .. .	15 0

Provided that where more than four (4) patients are seen, sessional payments should apply.

Where special procedures are carried out involving an hour or more at the Home, sessional payments should apply.

(iii) **Emergency attendances—**

**Out of hours:**

First patient	.. .. .	£1 10 0
Each additional patient	.. .. .	15 0

(d) Mileage: 5s. per mile for each mile beyond two miles one way (8 a.m. to 8 p.m.); 7s. 6d. per mile for each mile beyond two miles one way (8 p.m. to 8 a.m.).

(e) That where a doctor is of the opinion that the remuneration proposed is inadequate for the work carried out, a different remuneration may be agreed upon.

With the exception of mileage fees which are at present under discussion the fees were accepted by the Department of Child Welfare.

The fees also apply to inmates of the Aborigines Girls' Home at Cootamundra, to the Kinchela Boys' Home at Kempsey and to indigent persons in aborigine reserves and in aborigine stations, approved by the officer-in-charge.

**Nurses' Registration Act, 1953-1955: Syllabus of Training  
(General Nursing).**

Following submissions made from time to time by members of the medical profession in regard to the Syllabus of Training of Nurses (General Nursing), the Council appointed a special committee to consider the matter.



## NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

## BRANCH ACCOUNT.

## Income and Expenditure Account for the Year ended December 31, 1959.

	£	s.	d.	£	s.	d.		£	s.	d.	£	s.	d.
To Salaries .....	16,775	0	1				By Subscription Revenue .....				45,177	5	6
" Rent of Offices, etc. ....	1,200	0	0				Less Proportion due to—						
" Printing and Stationery ..	3,157	16	3				British Medical Association .....	6,635	15	0			
" Stamps and Telegrams ..	601	1	7				THE MEDICAL JOURNAL OF						
" Telephones .....	517	5	0				AUSTRALIA .....	2,054	0	0			
" Travelling Expenses, General	685	11	8								8,689	15	0
" Code Address .....	3	8	0										
" Insurances .....	100	10	8								36,487	10	6
" Exchange and Bank Charges	13	2	2				" Interest—						
" Refreshments—Meetings ..	81	7	9				Australasian Medical Pub-						
" Newspapers and Advertising ..	85	12	8				lishing Co. Ltd. ....	1,106	7	9			
" Sundry Petty Expenses ..	223	4	10				Commonwealth Treasury						
" Tea Money .....	155	5	3				Bonds .....	215	7	6			
" Federal Council .....	5,158	15	0								1,321	15	3
" Repairs and Maintenance—							" Rent, Assembly Hall .....				530	5	0
Equipment .....	106	2	2				" Broadcasting and Journalist						
" Pay Roll Tax .....	286	11	8				Fees .....				22	13	4
" Medical Benefits—Staff ..	40	17	3										
" Staff Superannuation Funds ..	1,079	1	8										
" Incidental, Travelling and													
Entertainment Expenses ..	324	0	0										
" Stamp Duty .....	71	15	0										
" Laundry .....	31	15	7										
" Branch Prize and Medal ..	107	16	8										
" Public Relations Campaign ..	1,318	17	1										
				32,124	13	0							
" Allowance for Depreciation—													
Library .....	2,548	3	6										
Furniture and Equipment ..	390	7	7										
				2,938	11	1							
" Provision for Long Service													
Leave .....				200	0	0							
" Provision for Medical Prac-													
titioners' Handbook .....				1,000	0	0							
" Surplus for Year transferred													
to Accumulated Funds ..				2,098	15	0							
				£38,362	4	1					£38,362	4	1

The special committee submitted a report to Council, which was adopted.

The report stated that, having examined the courses of study as detailed in the Regulations under the *Nurses' Registration Act, 1953-1955*, and considered the opinions obtained from matrons and tutor sisters at various hospitals, and having regard to their own personal experience in the subject of lecturing nurses, the committee was of the opinion—

1. That in view of the multiplicity of procedures that are integral parts of the practice of modern medicine, the present syllabus of training of nurses appears to be appropriate.
2. That the minimum times allocated for the various subjects are satisfactory.
3. That it is possible that a major defect in the present training of nurses is that some lecturers appear to lack an appreciation of the standard required for the nursing profession and that lectures are made too comprehensive.

For the information of members a copy of the report was published in the *Monthly Bulletin*.

A copy was also forwarded to the Nurses' Registration Board.

## Blood Transfusion Without Consent.

At the end of 1958 a communication was received from the Director-General of Public Health seeking the views of the Association in regard to legislation which the Government intended to introduce in connexion with the refusal of a parent (or guardian) to give permission for a blood transfusion to a child in order to save its life.

The Director-General of Public Health was advised that the responsibility for determining whether a transfusion should be given when the parents have refused to give their consent, should rest with some legal authority who would be empowered to transfer the custody of the child from the parents to a Child Welfare officer. Council was further of the opinion that the legal procedure to be adopted should be such as to permit of a rapid decision.

It was considered by Council that any decision by a medical practitioner must be restricted to one concerning the medical needs.

## Poisons Information Centre.

During the year the Council submitted to the State Minister for Health a "Report on Possible Arrangements for the Implementation of a Poisons Information Centre". The report had been prepared by Professor R. H. Thorp, Ph.D. (Med.), B.Sc., Professor of Pharmacology, University of Sydney, after discussions with the Organization and Science Committee of Council.

The report dealt with the matters of (a) staffing, (b) method of functioning, and (c) finance.

## Paraplegic Survey.

In the issue of THE MEDICAL JOURNAL OF AUSTRALIA of December 19, 1959, there was published an article on a paraplegic survey which Council had decided to conduct in the latter part of 1957.

The object of the survey was to obtain information concerning the number of persons affected and the problems involved in caring for them, with a view to estimating the number of beds required in one or more paraplegic centres and paraplegic hostels.

A summary of the survey stated the following:

A pilot survey of paraplegics in New South Wales has been carried out. It was not sufficiently supported or forceful to be as successful as such a survey needs to be. Nevertheless, the following firm conclusions could be drawn:

1. A significant percentage of accidents causing paraplegia are preventable.
2. If adequately treated early, and thereafter followed up for life, 70% to 80% of paraplegics in the young and middle-aged groups are employable.
3. There is a need in the State of New South Wales for at least one modern fifty-bed paraplegic unit, situated in Sydney and associated with a teaching hospital, to satisfy present and future needs in treatment, teaching and research.

## Salk Vaccine.

The Council has never ceased to maintain throughout the year that Salk vaccine should be made available to private

practitioners. In this it had the support of the State Minister for Health and the Director-General of Public Health, New South Wales.

However, representations by the Federal Council failed to influence the Commonwealth Government to release the vaccine to private practitioners.

#### Workers' Compensation Act: Silicosis Committee.

Following representations made to the Silicosis Committee advice was received from that body that it had agreed that in any case of illness associated with and attributable to silicosis which occurred after a period of three months, payment would be made on the basis of a first attendance.

#### Medical Examination of Motor Vehicle Drivers.

At the invitation of the Commissioner for Road Transport, a representative of Council attended a conference of various organizations to consider the question of requiring all classes of motor vehicle drivers to undergo medical examination.

It was submitted to the conference, as the Association's opinion, that of all accidents the cause of which could have been attributable to physical disabilities, only a small proportion would have been avoided by prior medical examination.

#### Golf Tournament.

The annual golf tournament for the British Medical Association Cup presented by the late Dr. H. C. Rutherford Darling was held on the golf course of the Australian Golf Club at Kensington on Tuesday, November 24, 1959.

The winner was Dr. D. G. Tracy, and the runner up was Dr. V. J. McGovern.

#### British Medical Agency of New South Wales Limited.

The directors reported that for the year ended June 30, 1959, the operations of the company resulted in a net profit of £2,506 16s. 4d. as compared with a loss of £712 7s. 9d. for the previous year, representing an increase of net profit to the extent of £3,219 4s. 1d.

The directors confidently expect that, with a continuation of further support from the profession, the present trend of increased profits will be maintained and expanded, thus enabling the company to provide further services for the medical profession in New South Wales.

#### Medical Finance Limited.

The directors reported that for the year ended June 30, 1959, there was a net profit of £43 14s. 5d. as compared with a profit of £14 4s. 4d. for the previous year.

During the year the company did not advance any further funds to practitioners in view of the arrangement with its bankers, under which, in approved cases, finance may be made available by them to members of the profession requiring financial assistance when entering into practice.

#### Premises Revenue Account.

The premises revenue account discloses a net surplus of £4,664 for the year ended December 31, 1959, as against a net surplus of £5,612 for the year ended December 31, 1958, thus showing a decrease of £948 in net revenue earned. This decrease is accounted for by a decrease in net income of £148 in addition to a net increase in expenditure of £800 as detailed in the accompanying comparative statement.

A comparison of percentages of expenditure to rent revenue with those of December 31, 1958, is as follows:

	1958	1959
Percentages of expenses to revenue ..	88.8	87.8
Percentages of surplus to revenue ..	11.2	12.2
	100%	100%

The percentage of rent revenue, expenses and depreciation and the percentage of net surplus for the year to capital value of the land and building (British Medical Association House) as shown by the books at December 31, 1959, namely £117,912, with the previous year's percentages in parentheses are as follows:

Rent revenue (including amount charged for British Medical Association Branch offices, etc.) .. .. .	32.45%	(30.62%)
Sundry expenses, interest, provision for painting, etc. .. .	26.12%	(24.35%)
Depreciation of building .. .	2.37%	28.49% (2.32%)
		3.96% (3.95%)

#### Financial Statement.

The Council has pleasure in presenting to members the balance sheet and accounts in respect of the financial year which terminated on December 31, 1959. The net surplus of revenue over expenditure amounted to £6,763 5s. 8d. after making provision for all known expenditure.

The sum of £5,917 10s. 1d. has been written off for depreciation of the building (British Medical Association House), plant, office furniture, equipment and the Library.

The sum of £800 has been provided out of the current year's revenue to create a reserve for painting of the exterior of the building. Provision for long service leave has been increased by £300.

M. S. ALEXANDER,  
President.

The balance sheet of the Branch and the income and expenditure account of the Branch and of the premises were received on the motion of Dr. W. F. Simmons, seconded by Dr. R. H. Macdonald.

#### ELECTION OF OFFICE BEARERS.

Dr. Munro Alexander then announced that the following had been elected to the Council as representatives of the general body of members for the ensuing year: Dr. E. A. Booth, Dr. D. A. Brown, Dr. W. L. Calov, Dr. J. F. C. C. Copley, Dr. D. G. Hamilton, Dr. G. L. Howe, Dr. R. H. Macdonald, Dr. A. E. McGuinness, Dr. A. J. Murray, Dr. T. Y. Nelson, Dr. J. A. Paul, Dr. K. C. T. Rawle, Dr. W. F. Simmons, Dr. E. S. Stuckey, Dr. E. F. Thomson, Dr. P. A. Tomlinson.

Elected as representing women members: Dr. Mary C. Puckey.

Elected as representing the Public (Government) Medical Services: Dr. L. W. Wing.

Elected as representing metropolitan local associations: Dr. K. W. Alexander, Dr. K. S. Jones.

Elected as representing country local associations: Dr. M. C. McKinnon, Dr. B. W. Monahan.

#### ELECTION OF AUDITORS.

Messrs. F. W. Duesbury and Company were elected auditors for the ensuing year.

#### ELECTION OF REPRESENTATIVES OF THE BRANCH AT THE ANNUAL REPRESENTATIVE MEETING OF THE BRITISH MEDICAL ASSOCIATION, 1960, AT TORQUAY.

On the motion of Dr. A. J. Murray, seconded by Dr. E. F. Thomson, it was resolved that the appointment of representatives of the New South Wales Branch to attend the annual meeting of the British Medical Association on June 15 to 24, 1960, at Torquay, should be left in the hands of the Executive Officers.

#### PRESENTATION OF THE ANNUAL BRANCH PRIZE FOR AN ESSAY ON A SCIENTIFIC SUBJECT.

Dr. Munro Alexander presented the annual Branch prize for an essay on a scientific subject to Dr. W. J. Garrett, for his essay on "Disordered Uterine Action".

#### INCOMING PRESIDENT'S ADDRESS.

Dr. B. A. Cook delivered his incoming president's address entitled "Thoughts of a New President" (see page 873).

A vote of thanks to Dr. Alexander for his address was carried on the motion of Dr. D. G. Hamilton, seconded by Dr. G. L. Howe.

#### INDUCTION OF PRESIDENT.

Dr. Munro Alexander inducted the President for the year 1960-1961, Dr. B. A. Cook, and invested him with the presidential badge of office. Dr. Cook thanked the members for his election.

## Congresses.

### VICTORIAN CANCER CONGRESS.

THE Victorian Cancer Congress will be held at the University of Melbourne from August 22 to 25, 1960. Registration forms are available from the Honorary Organizing Secretary, F. Douglas Stephens, F.R.A.C.S., 410 Albert Street, East Melbourne, C.2, Victoria.

#### Scientific Programme.

The programme is as follows:

**Monday, August 22:** Plenary Session, "Carcinogenesis": Chairman, Professor E. S. J. King.

9 a.m., "The Significance of Experimental Tumours for Human Tumour Causation", Professor R. A. Willis (Great Britain); 9.40 a.m., discussion—opening speaker, Associate Professor G. S. Christie (Victoria); 9.50 a.m., "Current Concepts on the Mechanism of Action of Chemical Carcinogens", Professor J. A. Miller (U.S.A.); 10.30 a.m., discussion—opening speaker, Professor T. Yoshida (Japan); 11.10 a.m., "Hormonal Aspects of Carcinogenesis", Dr. F. Bielschowsky (New Zealand); 11.50 a.m., discussion—opening speaker, Professor P. C. Koller (Great Britain); 12 noon, "Cancer Hazards in Everyday Life", Professor W. E. Davies (Victoria); 12.40 p.m., discussion—opening speaker, Professor I. Berenblum (Israel).

**Monday, August 22:** Plenary Session, "Cancer in the Community": Chairman, Cr. W. J. Kilpatrick.

2 p.m., "Oral Cancer in India and its Relation to Certain Habits", Professor V. R. Khanolkar (India); 2.25 p.m., discussion—opening speaker, Mr. F. G. Smyth (Port Moresby); 2.40 p.m., "Public Attitudes Relevant to Cancer Education", Dr. G. Gardner (Victoria); 3.05 p.m., discussion—opening speaker: Mr. W. A. Dick (Victoria); 3.35 p.m., "A Critical Survey of Cancer Films", Mr. R. J. Thompson (Victoria); 4.05 p.m., (a) screening of films, (b) discussion—opening speaker, Mr. Newman Rosenthal (Victoria).

**Tuesday, August 23:** Plenary Session, "Cancer of the Lung": Chairman, Dr. C. H. Fitts.

9 a.m., "The Incidence, Types and Modes of Spread of Pulmonary Tumours, with Comments on Some Fallacies and Uncertainties", Professor R. A. Willis (Great Britain); 9.50 a.m., "Towards a Solution of the Lung Cancer-Smoking Problem", Dr. E. L. Wynder (U.S.A.); 10.35 a.m., discussion; 11.15 a.m., "The Significance of Mass X-Ray Surveys in Cancer of the Lung", Dr. B. Cleerehan (Victoria); discussion—opening speaker, Dr. C. Rubinstein; 11.35 a.m., "Exfoliative Cytology in Diagnosis of Cancer of the Lung", Dr. Stephen E. Williams (New Zealand); 12.05 p.m., "A Survey on the Results of Treatment of Cancer of the Lung: (a) Surgery, (b) Radiotherapy, (c) Chemotherapy", Mr. C. J. Officer Brown (Victoria); 12.30 p.m., discussion—opening speaker, Mr. G. Rowan Nicks (New South Wales); 12.45 p.m., Telecast: "Television as an Aid in Diagnosis", Professor M. R. Ewing (Victoria), Dr. G. Berci (Victoria).

**Tuesday, August 23:** Afternoon Sectional Meeting, "Carcinogenesis": Chairman, Dr. J. Perry.

2 p.m., "Chromosomes of Malignant Cells", Professor P. C. Koller (Great Britain); 2.30 p.m., discussion—opening speaker, Professor R. A. Willis (Great Britain); 2.40 p.m., "DPN and TPN Synthesis in Relation to Malignancy", Professor R. K. Morton (South Australia); 3 p.m., discussion—opening speaker, Professor J. A. Miller (U.S.A.); 3.10 p.m., "Enzymes of Red Cells in Malignancy", Mr. I. C. Parsons (Victoria); 3.30 p.m., discussion—opening speaker, Dr. P. Alexander (Great Britain); 4 p.m., "Studies on Leukemogenesis in Mice—Adrenal Cortical Function", Dr. D. Metcalf (Victoria); 4.20 p.m., discussion—opening speaker, Professor P. C. Koller (Great Britain); 4.25 p.m., "Fluorescein Globulin Staining of Tissues", Dr. C. J. Louis (Victoria); 4.40 p.m., discussion—opening speaker, Professor E. Miller (U.S.A.); 4.45 p.m., "Histochemical Demonstration of Nucleic Acids", Dr. D. W. Menzies (Victoria); 4.55 p.m., discussion—opening speaker, Dr. F. Bielschowsky (New Zealand).

**Tuesday, August 23:** Afternoon Sectional Meeting, "Cancer in the Community": Chairman, Dr. K. Brennan.

2 p.m., "Voluntary Community Effort in the Field of Cancer", Cr. W. J. Kilpatrick (Victoria); 2.20 p.m., "Social Welfare of Cancer Patients in Victoria", Mrs. B. Thomas

(Victoria); 2.40 p.m., discussion—opening speaker, Dr. J. H. Lindell (Victoria); 2.50 p.m., "What Should the Patient be Told?", Sir William Upjohn (Victoria); 3.15 p.m., discussion—opening speaker, Miss K. Ogilvie (New South Wales); 3.50 p.m., "Palliative Treatment of Advanced Cancer", Mr. Victor Stone (Victoria); 4.10 p.m., "Dietetic Care of Cancer Patients", Miss C. N. Turner (Victoria); 4.30 p.m., "Rehabilitation after Cancer of the Larynx", Mr. Bernard Shelverton (Tasmania); 4.50 p.m., discussion—opening speaker, Mr. F. D. Burke (Victoria).

**Wednesday, August 24:** Plenary Session, "Leukæmia": Chairman, Dr. Ian Wood.

9 a.m., "Some Clinical Problems of Leukæmia", Professor H. N. Robson (South Australia); 9.20 a.m., "The Age Incidence of Leukæmia", Dr. E. V. Keogh (Victoria); 9.40 a.m., "Organization of Clinical Trials in Leukæmia and Comparative Evaluation of Clinical Agents", Dr. D. A. G. Galton (Great Britain); 10.10 a.m., discussion—speakers, Dr. F. Gunz (New Zealand), Dr. J. Bolton (Victoria); 11 a.m., "Leukemogenesis", Dr. Jacob Furth (U.S.A.); 11.40 a.m., "Lymphocytic Homeostasis in the Pathogenesis of Lymphoid Leukemia", Dr. D. Metcalf (Victoria); 12 noon, discussion—opening speaker, Sir Macfarlane Burnet (Victoria).

**Wednesday, August 24:** Afternoon Sectional Meeting, "Carcinogenesis": Chairman, Dr. T. E. Lowe.

2 p.m., "New Names in Tumour Terminology", Professor R. A. Willis (Great Britain); 2.35 p.m., discussion—opening speaker, Professor V. R. Khanolkar (India); 2.40 p.m., "Metabolic Fate and Carcinogenicity of 2-Acetylaminofluorene", Professor E. Miller (U.S.A.); 3 p.m., discussion; 3.05 p.m., "Mechanism of Cancer Induction by Impermeable Films", Dr. P. Alexander (Great Britain); 3.35 p.m., discussion—opening speaker, Professor W. E. Davies (Victoria); 4 p.m., "Antigenicity of Malignant Tissue", Dr. S. Wiener (Victoria); 4.20 p.m., "Dimethylnitrosamine Carcinogenesis", Associate Professor G. S. Christie (Victoria); 4.30 p.m., "Canine Ovarian Tumours following Stilbestrol Administration", Miss A. Jabara (Victoria); 4.40 p.m., discussion—speakers, Dr. F. Bielschowsky (New Zealand), Professor I. Berenblum (Israel).

**Wednesday, August 24:** Afternoon Sectional Meeting, "Leukæmia": Chairman, Professor J. D. Hayden (Victoria).

2 p.m., "The Place of Radiotherapy in Treatment of Leukæmia", Dr. J. Madigan (Victoria); 2.20 p.m., "Chemotherapy in Leukæmia", Dr. D. A. G. Galton (Great Britain); 2.40 p.m., "Splenectomy in Leukemia and Allied Disorders", Dr. C. de Gruchy (Victoria); 2.55 p.m., "Leukæmia in Childhood", Dr. J. Colebatch (Victoria); 3.15 p.m., discussion—opening speaker, Dr. J. McLean (Victoria); 3.55 p.m., "The Nature of Acquired Drug Resistance", Professor T. Yoshida (Japan); 4.15 p.m., "Leukosarcoma", Dr. R. Motteram (Victoria); 4.30 p.m., "Leucocyte Alkaline Phosphatase in Leukæmia", Dr. R. Wyllie (Victoria); 4.40 p.m., discussion.

**Thursday, August 25:** Plenary Session, "Cancer of the Skin": Chairman, Professor M. R. Ewing.

9 a.m., "Skin Cancer as an Australian Problem: (i) A Current Survey in Victoria", Dr. G. Read (Victoria); 9.10 a.m., "Skin Cancer as an Australian Problem: (ii) An Aetiological Study", Dr. G. G. Carmichael (Queensland); 9.25 a.m., discussion—opening speaker, Professor V. R. Khanolkar (India); 9.35 a.m., "Precancerous Skin Changes Caused by Solar Radiation—A Pathological Study", Dr. V. J. McGovern (New South Wales); 9.55 a.m., discussion—opening speaker, Dr. J. D. Hicks (Victoria); 10 a.m., "Some Clinical Observations: (i) On Precancerous Skin Conditions", Dr. D. Clarke (Victoria); 10.15 a.m., "Some Clinical Observations: (ii) On Inevitable Cancerous Change in Some Skin Lesions", Mr. B. K. Rank (Victoria); 10.30 a.m., discussion—opening speaker, Dr. Eric H. Taft; 11.10 a.m., "Carcinogenesis in Relation to Skin Cancer", Professor I. Berenblum (Israel); 11.55 a.m., discussion—opening speakers, Professor R. A. Willis (Great Britain).

**Thursday, August 25:** Television Demonstration.

12.15 p.m., "The Potential of Television in Post-Graduate Medical Education", Professor M. R. Ewing (Victoria), Dr. G. Berci (Victoria).

**Thursday, August 25:** Afternoon Sectional Meeting, "Cancer of the Skin": Chairman, Mr. Charles Osborn.

2 p.m., "Molluscum Sebaceum—Its Clinical and Aetiological Significance", Mr. J. H. Heslop (New Zealand); 2.20 p.m., "An Unusual Epithelioma in Inbred Sheep", Dr. L. C. Lloyd (New South Wales); 2.40 p.m., discussion—opening speaker, Mr. J. T. Hueston (Victoria); 3 p.m., "Melanoma—



The Liaison Between Pathologist and Surgeon", Dr. J. D. Hicks (Victoria); 3.15 p.m., discussion—speaker, Dr. A. V. Jackson (Victoria); 4 p.m., "Management of Carcinoma of the Skin: (i) Experience in Queensland", Dr. A. G. S. Cooper (Queensland); 4.20 p.m., "Management of Carcinoma of the Skin: (ii) Some Experience in a Combined Clinic", Dr. C. C. J. Minty (Victoria), Mr. A. R. Wakefield (Victoria); 4.50 p.m., discussion—speakers, Dr. J. C. Belisario (New South Wales), Mr. I. Heinz (Victoria), Dr. H. A. S. van den Brenk (Victoria).

**Thursday, August 25:** Afternoon Sectional Meeting, "Cancer of the Lung": Chairman, Mr. C. J. Officer Brown.

2 p.m., "The Management of Inoperable Cancer of the Lung", Mr. J. Hayward (Victoria); 2.15 p.m., "Symptomatic Management of Inoperable Cancer of the Lung", Dr. W. P. Holman (Victoria); 2.30 p.m., "Social Aspects of the Diagnosis of Inoperable Cancer of the Lung", Miss N. Fancourt (Victoria); 2.45 p.m., discussion—opening speaker, Dr. J. E. Clarke (Victoria); 2.55 p.m., "The Management of the Pulmonary Coin Lesion", Mr. Ken Morris (Victoria); 3.20 p.m., discussion—opening speaker, Mr. Ian McConchie (Victoria); 3.50 p.m., "Some Aspects of Pulmonary Function Studies in the Preoperative Selection of Patients", Dr. Malcolm Allen (Victoria); 4.10 p.m., discussion—opening speaker, Dr. Bryan Gandevia (Victoria); 4.20 p.m., "Results of Resection of Pulmonary Metastases", Mr. Howard Brown (South Australia); 4.40 p.m., discussion—opening speaker, Mr. J. K. Clarebrough (Victoria).

#### Museum Exhibits.

"Epithelial Tumours of the Bladder, Ureter and Kidney Pelvis", Dr. A. V. Jackson; "The Value of Special Radiological Procedures in the Diagnosis of Cancer of the Lung", Dr. H. A. Luke; "Clinical and Pathological Patterns in Lung Tumours", Dr. R. J. Riddell, Dr. C. R. Green; "Radioactive Isotopes in Hematological Investigation", Dr. R. Mottram; "Radiophosphorus in the Diagnosis of Malignant Melanoma", H. A. S. van den Brenk, K. H. Clarke (Physicist), K. Liddett; "Skin Cancer", Dr. J. D. Hicks, Dr. S. O. M. Were, Mr. A. R. Wakefield, Dr. C. C. J. Minty; "Transverse Tomography in the Planning of Radiotherapy for Tumours of the Thorax", Dr. B. L. Deans, K. H. Clarke (physicist); "Treatment of Cancer of the Cervix by Radiotherapy", Dr. G. R. Kurrel; "Use of High Energy Electron Beams in Radiotherapy", K. H. Clarke (physicist); "Statistical Charts Showing Various Aspects of the Incidence of Cancer in Victoria", Cynthia McCall; "Ocular Tumours", Dr. C. H. Greer; "Cancer of the Head and Neck", Dr. J. P. Madigan; "Tumours of Bone and Cartilage", Dr. J. F. Funder, Dr. M. Drake; "Cytotoxic Treatment of Cancer", Dr. R. H. D. Bean; "Embryonic Tumours", Dr. A. L. Williams, Dr. L. J. Cussen; "Macroglobulinemia", Dr. Ian Mackay; "Gastrophotography as an Aid to the Diagnosis of Cancer", Dr. Ian J. Wood; "The Place of Surgical Reconstruction and Prosthesis for Post-Cancer Defects of the Face", B. K. Rank, C. Wellington (prosthetic technician); "Change in Serum Vitamin B<sub>12</sub> in Malignant Disease", Dr. D. C. Cowling; "The Correlation of Cytological and Histological Findings in Carcinoma in Situ of the Cervix Uteri and its Related Conditions", Dr. H. F. Bettinger, Dr. R. A. Barter, Dr. G. Jacob; "Ancillary Methods in the Diagnosis of Lung Cancer", Mr. J. K. Clarebrough, Dr. S. Clifton; "Bone Marrow Trephine Biopsy: Its Diagnostic Value with Particular Reference to the Malignant Lymphomas", Dr. G. C. de Gruchy, Dr. J. P. Carew; "Low Power Electron Microscopy of Tumours", Dr. S. Weiner, S. J. Oertels (electron microscopist); "Spontaneous Tumours of Domestic Animals", G. S. Christie, D. Leaver (veterinary surgeon); "Dimethylnitrosamine Carcinogenesis", G. S. Christie, R. N. Le Page (graduate research assistant); "Tumours of the Rat Experimentally Produced by 3:2'-Dimethyl-4-Aminodiphenyl", E. S. J. King, G. Varasdi (research assistant); "Tumours of the Central Nervous System—Classification, Histology and Radiology", Dr. R. McD. Anderson; "Fluorescein-Globulin Staining of Tissues", Dr. C. J. Louis; "Spontaneous Canine Growths", Anne L. Jabara; "Tumours of the Pituitary Gland and Surrounding Structures", Mr. R. Hooper, Dr. R. Anderson; "The Use of Television as a Diagnostic Aid", Dr. G. Bercl; "The Contribution of Regeneration of the Squamous Cervical Epithelium to the Problem of Carcinogenesis of Cancer of the Human Cervix", Dr. B. L. Reid; "Experiments on the Pathogenesis of Lymphoid Leukemia", Dr. D. Metcalf; "Relationship of Viruses to Malignant Disease", Dr. J. T. Grace, junior, Dr. E. A. Mirand, Dr. G. E. Moore; "Office Cytodiagnosis for Cutaneous Tumours", Dr. R. A. Langley; "The Cytological Diagnosis of Lung Cancer", Dr. S. E. Williams; "Malignant Disease of the Skin in Negroids of Australian New Guinea", Dr. J. J. Saave.

## Out of the Past.

### THE MOTOR IN MEDICAL PRACTICE.<sup>1</sup>

By Alfred Foster L.R.C.P., Wahroonga.

[From the *Australasian Medical Gazette*, October, 1901.]

In order to reply to the many queries made since I first used a motor in my practice I am publishing a résumé of my experiences. The motor is a 2½ h.p. de Dion convertible quad or tricycle. It is comfortable on good roads as a tricycle but rough on bad, being comfortable as a "quad" for the passenger in front but less so for the driver. Steering and control are perfect. The pace varies from 3 to 30 miles per hour, 16 miles an hour is ample. The cost of running is from ½ to 1 penny per mile according to the condition of the road. The driving is perfectly simple and easily learned. The diagnosis of faults constitutes the real difficulty in dealing with any motor. I have been delayed even an hour, but when discovered the fault was easily put right in five minutes: experience is necessary. The machine, in good weather, with this reservation is perfectly reliable, but in bad weather requires many improvements and modifications. I had no trouble till the bad weather began.

Having collected a mass of information on the subject, I will give a summary of the points to be considered before making a purchase.

The idea is undoubtedly correct and in England and the Continent is a practical success. In Australia it is quite otherwise until machines are built for the purpose. Do not be misled by isolated experience, nine months trial and success are necessary before any type of motor can be said to be suitable. Anyone reading the report of the 1000 mile trial of the Automobile Cluo will appreciate that the chief source of failure being from breaks of wheels and axles (not the motor proper) it would be useless to expect a motor built for the English market to stand on Australian roads. This is because the road gauge is about 4 inches more than the English: the bump between the wheels acts as a wedge and something must go. A motor must be either five feet 2 inches gauge or else less than 48 inches which is the average size of the bump between the ruts. A few inches more or less converts the road into a wedge that ruins the whole wheel and axles. The spirit costs in Sydney just double what it costs in England and there is freight to be added. I am informed that two shillings per gallon and freight from Sydney is likely to be the minimum. Thus a 6 horsepower engine, such as is now being sold in Sydney, costs 1½ per mile to run for spirit alone. Thus, the engine must be of the smallest horsepower compatible with efficient work, or the cost of running becomes prohibitive.

I have prepared a comparison of our present horse and motor costs.

My average verified runs amount to say, 100 miles per week. Horse keep and repairs to vehicle but excluding wage total 16 shillings per week. Running costs of a car with repairs 8 shillings per week.

I use a bicycle a good deal but my horse costs me none the less. Except for sinking fund my motor costs me nothing when not in use. If prepared to take the trouble anyone can understand how to manage a motor. A medical man especially. It doubles my earning capacity.

## Correspondence.

### A FORTUNATE JUXTAPOSITION.

SIR: It is a liberty which I feel compelled to take to commend you upon your two leading articles of today's issue (Saturday, May 21, 1960), the one announcing formal approval and the blessing of the Parent Body of the British Medical Association to our intention to proceed with the formation of the Australian Medical Association, and the other with the standards required of a man and a doctor in the face of the stern challenge of our times—"a decent bloke". This juxtaposition stands as a breath of genius, leading long thoughts naturally to the contemplation of the sublimities of the meaning of the Kokoda Trail, Anzac and Dunkirk, with "an humble and a contrite heart".

<sup>1</sup> From the original in the Mitchell Library, Sydney.

As you have well said, Sir, affiliation of our new Association with the British Medical Association is expected in Australia, and furthermore, it is a sincere desire that through it the bonds and ties of our heritage will be hallowed and strengthened.

Yours, etc.,

J. FRASER BOAG.

"Glengairn",  
671 Garfield Road,  
Riverstone, N.S.W.  
May 21, 1960.

#### SURGERY AND THE GENERAL PRACTITIONER AND PROFESSIONAL UNITY.

SIR: A full-page article appeared in the *Australian Women's Weekly* (May 4) allegedly written by a highly qualified specialist. That this added thinking could emanate from a mind which had reached such academic eminence is beyond comprehension.

We are informed that the writer's ethics forbade publication of his name. How paradoxical that the same code of ethics should permit him to prostitute the profession publicly in a weekly periodical! We would challenge the author to shed his cloak of anonymity and publish his name in the more appropriate columns of this Journal.

Not only has he charged the general practitioner surgeon with technical incompetence, but grossly insulted him by questioning his moral conduct. He has attempted to create a façade of argument without presenting one concrete fact to support it. The ultimate judgement of any surgeon's capability will evolve, not upon the number of letters appended to his name, but upon the results achieved. In this regard, a comparison of the results of operations on which this person has based his argument—namely, appendicectomy and tonsillectomy—would be far more convincing than an obviously ill-formed statement. We would be prepared to produce figures and be judged on the results. Would the writer be prepared to do the same?

Considering in detail some of the points in this pathetic article:

1. It is noted that general practitioner surgeons do not operate, but surgically assault their patients. Further, they often operate because they are unsure of their diagnosis and the relatives exert pressure.
2. Financial interest in the operation. Are we expected to be so naïve as to think that the specialist has no pecuniary interest in the surgery he performs so well, when his fee often is so far in excess of that of his general practitioner colleague?
3. "Patching the mess"—the analogy of the motor mechanic and the Jaguar and Rolls Royce is utter nonsense. Need we say any more than that the majority of cars on the road are Holdens?
4. The B.M.A. naturally represents the majority of doctors, although in fact most of its Council members are specialists.
5. "Losing face with patients by referring them to specialists usually at some distance from his practice." This is again utter nonsense. The chief reason for this is that so few of the specialists are willing to accept the responsibility of venturing outside the portals of Collins and Macquarie Streets.
6. It is claimed that skilled surgical attention is obtainable only at the hands of the specialist. How remarkable it is that so many victims of unqualified surgical assault have managed to survive in the past!
7. The purchase and sale of goodwill has always been a principle of medical practice, and can only be regarded as an index of the integrity and capability of the doctor creating it. Patients are not the fools which our unenlightened author would have us believe, and they reserve the right to go to the doctor in whom they have faith.
8. The College of General Practitioners. This worthy body is attempting to do for the general practitioner precisely what the specialist Colleges are attempting to do for their members. It seeks to improve standards, and its members are pledged to undergo a certain period of post-graduate study annually. This includes surgery. It is interesting to note that cooperation has been forthcoming from Physicians and Obstetricians, but noticeably lacking from the College of Surgeons.

9. Federal decision. This statement comes from a man who has obviously accepted the inevitability of nationalization. As far as he is concerned, the battle has been lost before it has begun. We abhor the concept which would have medical practice in all its phases controlled by public servants—a situation in which mediocrity, chronological seniority and subservience would be the yardstick for promotion.

We can only hope that the expression of these views by "Mr." X is not a reflection of the opinion of the College of Surgeons. If this belief is correct, it calls for a public retraction and apology through the same columns as were chosen with such complete disregard for ethical standards.

What does this publication pay for a full-page article?

Yours, etc.,

H. T. McDONALD (Kerang),  
R. L. GODFREY (Kerang),  
W. D. JACKSON (Pyramid Hill),

17 Scoresby Street,  
Kerang,  
Victoria.  
April 26, 1960.

#### Obituary.

##### LINDSEY PAGE WINTERBOTHAM.

LINDSEY PAGE WINTERBOTHAM died in Brisbane on February 26, 1960, after a short illness. His passing marks the end of the period of the "horse and buggy" doctor in Brisbane, for he was one of the last and one of the most outstanding of the old style of family doctor, who was friend, counsellor and medical adviser to his patients.

He was born in Adelaide on April 14, 1887, and was educated at St. Peter's College. He entered the University of Adelaide at the age of 16 years, and studied there for two years; the last three years of his medical course he completed at the University of Melbourne. He was blessed with an outstanding memory (due, no doubt, in no small measure to the early training he received from his parents), and thus he had a good academic record—he graduated M.B., B.S., in 1907 at the age of 20 years. He was a resident medical officer at the Brisbane General Hospital for eighteen months—at that time the staff consisted of four medical officers—and then did locum-tenens work in various parts of Queensland, including Mt. Garnett, before taking up his first practice in Lowood, where he remained for four years. He then bought a practice at Ipswich Road, Brisbane, in October, 1913, where he remained until his death. He was honorary surgeon at the Mater Public Hospital from 1920 to 1925, and had to resign because of ill health. For many years he was visiting medical officer to the Blind, Deaf and Dumb Institute in Brisbane.

Lindsey Winterbotham was always a deeply religious man, and with his philosophy, his practical psychology and his religious beliefs, he was able to help many of his patients through difficult periods of their life. His patients always regarded him as a Christian gentleman, who was always scrupulously honest, and who was ever ready to give sound advice.

He was very active in the medico-political sphere of the B.M.A., and with a few of his colleagues organized the general practitioner group of the B.M.A. in 1939, and thus took a very definite part in preventing the threatening nationalization of medical practice from becoming established. He was chairman of the general practitioner group from 1939 to 1949. During this time he was also a Councillor of the Queensland Branch of the B.M.A., in which capacity he served on many committees, including the war-time petrol rationing committee and the committee of directors of the British Medical Agency (1940-1950). He was representative of the Queensland Branch on the Federal Council during this same period, and was president of the Queensland Branch in 1944. He was lecturer in medical ethics at the Queensland Medical School for many years.

During the war Lindsey Winterbotham was very active in medical aid post establishments, spending much zeal and time in training personnel for their respective positions. He was a member of the South Brisbane Rotary Club for 14 years, and there showed his spirit of willingness to serve the public. In this, as in all his work, he showed

unfailing enthusiasm, a capacity for inspiring others and an ability to lead and direct. He was insistent on accuracy, and was always full of determination to succeed. His general knowledge was an astonishment to many, for he could discourse on numerous topics, no doubt owing to his excellent memory, and to his avidity for reading books (of facts, seldom fiction). He had a particular liking for the poems of Rudyard Kipling, and was always ready to quote from them. He had numerous hobbies over the years, including stamp collecting and wireless (in its early days).

Although not a great participant in organized sport, he was a member of the University crew in Adelaide, and won his blue for lacrosse in Melbourne. He was president of the Annerley Bowling Club in 1940, and was a fair tennis player. He liked fishing, including deep-sea fishing, and shooting; he was an excellent shot with a gun, and better than average with a rifle.



—By courtesy of the *Telegraph*, Brisbane.

It was perhaps during the last decade of his life that he made the greatest contribution to Queensland, and indeed to Australia, for it was as the result of the inspiration of a patient-friend that he became greatly interested in anthropological work pertaining to the Australian aborigines. It was owing primarily to his efforts that the subject became part of the curriculum of the University of Queensland. Moreover, he was almost solely responsible for the collection and establishment of the Ethnological Museum at the University, of which he was honorary curator. He was instrumental in founding the Queensland Anthropological Society and was one of its first presidents (1954-1955). He did much original research work in anthropology, and was ever willing to give talks and lectures on the subject. Among his publications are the following: "Problems of Today and Tomorrow", 1944; "Congenital Cardiac Defects Associated with Maternal Rubella", 1946; the Jackson Lecture, "Primitive Medical Art and Primitive Medical Men of Australia", 1951; "Ceremonial Circumcision", 1959. "The Jinibara Tribe of South East Queensland" is to be published shortly.

Dr. Winterbotham has left a widow and family of five sons and one daughter, only one of the sons having followed him into the medical profession.

#### ARCHIBALD HECTOR MCINDOE.

THE death recently occurred in England of Sir Archibald McIndoe, C.B.E., at the early age of 59 years. He was a pupil of Sir Harold Gillies, and his work in developing and teaching the art of plastic surgery made its mark all over the world. Sir Archibald McIndoe was born and educated in New Zealand, where in 1923 he took the degrees of bachelor of medicine and bachelor of surgery of the Otago Medical School; he was awarded a medal for clinical medicine and surgery. In 1924 he was awarded a Mayo Foundation fellowship, and proceeded to the Mayo Clinic; three years later he received the degree of master of science in pathology from the Mayo Foundation and the University of Minnesota. In 1928 he was awarded a William White travelling scholarship and appointed assistant surgeon at the Mayo Clinic. Later he went to England, and became chief assistant to the plastic surgery department of St. Bartholomew's Hospital. In 1929 he took the degree of master of surgery of New Zealand, and in 1932 became a Fellow of the Royal College of Surgeons of England. The American College of Surgeons elected him a Fellow in 1934.

Possibly Sir Archibald McIndoe's outstanding work was that done during the second World War. He steadfastly refused to don uniform and be given a rank, and there are those who hold that this independent attitude greatly extended his sphere of usefulness. As consultant in plastic surgery to the Royal Air Force and surgeon-in-charge of the Queen Victoria Plastic and Jaw Injury Centre at East Grinstead, he not only mended the damaged bodies of badly burned airmen, but helped them to recover the will to conquer their disabilities and take their place again in the world. To this end he founded the Guinea Pig Club for 600 men on whom he himself had operated at East Grinstead, and he always maintained his interest in their later careers, being ever available to them for help and advice.

Sir Archibald McIndoe held appointments at a number of other hospitals. In 1939 he was Hunterian Professor at the Royal College of Surgeons, of the Council of which he was a member, and in 1958 was elected Vice-President. His outstanding work in the relief and rehabilitation of war casualties was widely recognized, and he received a number of honours. He was created a Commander of the Most Excellent Order of the British Empire in 1944 and knighted in 1947. He was also a Commander of the Legion of Honour, of the Order of the White Lion of Czechoslovakia, of the Order of Polonia Restituta and of the Order of Orange Nassau.

#### ROBERT CHARLES ESPINASSE BRODIE.

We are indebted to Dr. Edward Rosanove for the following account of the career of the late Dr. Robert Charles Espinasse Brodie.

Dr. R. C. E. Brodie, only son of the late Malcolm Brodie, died in Melbourne on February 10, 1960, at the age of 62.

My first contact with Bob Brodie was in 1928. He had recently returned from overseas with an F.R.C.S. (Edinburgh)—an unusual degree for a dermatologist—and joined the late Herman Lawrence, Melbourne's original dermatologist, as an assistant and later partner. Brodie turned out to be the last of a long line of dermatologists taught by Herman Lawrence.

Academically, his reputation stood very high. In 1938, he gained his M.R.A.C.P., and was admitted as a Fellow in 1947. He was assistant dermatologist to S. W. Shields at the Alfred Hospital from 1927 to 1947, and honorary dermatologist from 1948 to 1952. He was honorary consultant dermatologist to the Victorian Eye and Ear Hospital from 1928 to 1955. He had been President of the Victorian branch of the British Association of Dermatology, and of the Dermatological Association of Australia.

In 1941, he was appointed one of two dermatologists to the Australian Forces abroad, and it was at this time that I went into partnership with him. His work and his experiences in the Army aged him considerably, and with his limp and his almost completely bald head with a fringe around the edges, he was often referred to as "the little old doctor". In his childhood, he had fallen off a horse and broken his left thigh, and his was one of the first, if not the first, fracture treated by the Hamilton Russell method. Brodie's mother died when he was born, and he was brought up by an aunt. Some



years of his very early life were spent in Glasgow with two other aunts.

Brodie was an unusual character. His kindness to patients was extraordinary, and many took advantage of this. They would ring for an appointment, and he would tell them to come at any time even though his day was fully booked. Then, when he saw the long queue of waiting patients, he would growl: "What are these people doing here all together? There must be some mistake." His generosity knew no bounds. Many a card was torn up because the patient complained that he could not pay Collins Street fees, and the number of "blue cards" (non-paying patients' cards) grew steadily year by year.

Brodie stuck meticulously to the metric system, and nothing infuriated him more than to see a prescription made out with a mixture of the metric and standard systems. Even in his private life, he favoured the metric system. He asked his wife to get a new double-bed two metres wide, but she astonished the furniture man by asking for a bed two millimetres wide.

He was a simple man with simple pleasures. He loved his weekly game of golf, and was an avid reader. Any sort of good book was welcome. But his great absorbing hobby was trains—miniature and real. His knowledge of the world's trains was stupendous, and journals on trains, both local and overseas, arrived regularly. His wife said that when the last war broke out, he was so upset that to solace himself he went and played with his trains.

Bob Brodie was a devoted husband and father, and to his wife, Evelyn, and his son, Malcolm, goes our sincerest sympathy.

## Post-Graduate Work.

### THE POST-GRADUATE COMMITTEE IN MEDICINE IN THE UNIVERSITY OF SYDNEY.

#### WEEK-END COURSE IN RENAL DISEASES.

THE Post-Graduate Committee in Medicine in the University of Sydney announces that a week-end course in renal diseases will be held on Saturday and Sunday, June 18 and 19, in the Scot Skirving Lecture Theatre of the Royal Prince Alfred Hospital. The chairman of the course, which will be supervised by Dr. Ralph Reader, will be Dr. T. M. Greenaway, and the programme is as follows:

Saturday, June 18: 10.15 a.m., "The Role of the Kidney in Fluid and Electrolyte Disturbance", Dr. H. Malcolm Whyte; 11 a.m., "The Role of the Kidney in Acid-Base Disturbance", Dr. Ralph Reader; 11.45 a.m., "Acute Renal Failure", Dr. David Jeremy; 2 p.m., "Urinalysis and Laboratory Tests of Renal Function", Dr. W. E. L. Davies; 2.45 p.m., "Haematuria", Dr. H. H. Pearson; 4 p.m., "Management of Patients with Retention of Urine", Dr. H. G. Cummine.

Sunday, June 19: 9 a.m., "The Clinical Value of Renal Biopsy", Dr. J. R. Johnson; 9.45 a.m., "Glomerulonephritis", Dr. T. M. Greenaway; 11 a.m., "Nephrotic Syndrome", Dr. R. H. Vines; 11.45 a.m., "Pyelonephritis", Dr. John McDonald.

The fee for attendance is three guineas, and early written application, enclosing remittance, should be made to the Course Secretary, The Post-Graduate Committee in Medicine, 131 Macquarie Street, Sydney. Telephone: BU 4497-8. Telegraphic address: "Postgrad Sydney".

#### PROGRAMME FOR JULY, 1960.

THE following programme of courses has been arranged for the month of July, 1960.

#### Post-Graduate Training in Cardio-Vascular Diseases.

The third of the series of evening seminars on various aspects of cardio-vascular diseases, suitable both for general practitioners and for post-graduates studying for higher degrees or diplomas, will deal with heart disease in younger people. These seminars will be under the supervision of Dr. G. E. Bauer, and will be held in the Maitland Lecture

Hall, Sydney Hospital, from 8 to 10 p.m. on Wednesdays, July 6, 13, 20 and 27.

#### Week-End Course in Endocrinology.

A week-end course in endocrinology suitable for general practitioners will be held on July 16 and 17 in the Scot Skirving Lecture Theatre of the Royal Prince Alfred Hospital. The course will be under the supervision of Dr. K. S. Harrison, and the fee for attendance is three guineas.

#### Week-End Course in Orthopaedics.

A week-end course in orthopaedics suitable for general practitioners will be held on July 23 and 24 in the Students' Lecture Room, Royal North Shore Hospital. The course will be under the supervision of Dr. C. D. Langdon, and the fee for attendance is three guineas.

#### Week-End Course in Paediatrics.

A week-end course in paediatrics suitable for general practitioners will be held on July 30 and 31 in the Doreen Dew Lecture Theatre of the Royal Alexandra Hospital for Children under the supervision of the Director of the Institute of Child Health. The fee for attendance is £4.4s. without luncheons or £4.16s. including luncheons.

#### Course in Clinical Respiratory Physiology.

A course in clinical respiratory physiology will be conducted in the Department of Medicine, University of Sydney, during the months of July and August. The course, which will be supervised by the Professor of Medicine, Professor C. R. B. Blackburn, will be held at 4 p.m. on two afternoons per week for a period of five weeks, beginning on Tuesday, July 12, and continuing each Thursday and Tuesday thereafter until Thursday, August 11, with the exception of the first week in August, when the sessions will be held on Tuesday and Wednesday, August 2 and 3. Each session will consist of a lecture—demonstration—discussion of approximately one hour's duration. The fee for attendance is five guineas.

#### Course on the Management of Cardiac Arrest.

A one-day course in the management of cardiac arrest will be held on Friday, July 8, at the Royal Prince Alfred Hospital and the Department of Surgery in the University of Sydney. The main feature of the course will be a practical demonstration in the operating theatre of the New Medical School, where it will be possible to stop an animal's heart with fluothane after which candidates will be allowed to practise cardiac massage and accordingly become reasonably familiar with this emergency procedure. The course will be limited to 10 candidates, and the list will be closed as soon as this number has been reached. The fee for attendance is two guineas, or one guinea for members of the annual subscription course.

#### Details of Courses.

The detailed programme of the above-mentioned courses will be announced at a later date.

#### COURSE FOR PART II D.A.

A course for the Part II examination of the diploma in anaesthesia of the University of Sydney will begin on July 4 and continue for a period of three months. Lectures and demonstrations are held in the afternoons only, and the fee for attendance is forty guineas.

#### COURSES FOR PART II D.P.M. AND D.D.R.

Courses for the Part II examinations of the diploma in psychological medicine and the diploma in diagnostic radiology of the University of Sydney will begin on July 18 and continue for a period of seven and eight months respectively. The fees for attendance are: D.P.M. II, sixty guineas; D.D.R. II, fifty guineas. Lecture and demonstrations are held in the afternoons only. Information concerning requirements for the above-mentioned diplomas may be obtained from the office of the Committee.

#### METHOD OF ENROLMENT.

Early written application to attend any of the above-mentioned courses should be made to the Course Secretary, The Post-Graduate Committee in Medicine, 131 Macquarie Street, Sydney. Telephones: BU 4497-8. Telegraphic address: "Postgrad Sydney".

# ROYAL PRINCE ALFRED HOSPITAL: EAR, NOSE AND THROAT DEPARTMENT.

## Seminar Programme, 1960.

THE staff of the ear, nose and throat department of the Royal Prince Alfred Hospital will conduct a seminar on the second Saturday of every month at 8 a.m. in the Scot Skirving Lecture Theatre. The main speaker will not exceed forty minutes, and there will be a discussion at the conclusion of his remarks. All medical practitioners and clinical students are invited to attend.

At the next seminar, to be held on June 11, 1960, Dr. R. G. Mackay will speak on "Further Aspects of Rhinoplasty Surgery".

# Naval, Military and Air Force.

## APPOINTMENTS.

THE following appointments, changes etc. are published in the *Commonwealth of Australia Gazette*, No. 25, of April 7, 1960.

### ROYAL AUSTRALIAN AIR FORCE.

#### Permanent Air Force.

##### Medical Branch.

The resignation of Flight Lieutenant D. P. Adamson, M.B.E. (0310768), is accepted, 24th February, 1960.

The appointment of Pilot Officer (Student) I. L. Ferguson (0312882) is terminated, 13th January, 1960.

#### Air Force Reserve.

##### Medical Branch.

Hans Peter Roeser (015318) is provisionally appointed to a commission, 15th December, 1959, with the rank of Pilot Officer.

The notification regarding the termination of appointment of Flight Lieutenant (Temporary Wing Commander) B. T. Mayes (264848) as approved in Executive Council Minute No. 43 of 1959, appearing in Gazette No. 76 dated 3rd December, 1959, is withdrawn.

# University Intelligence.

## THE UNIVERSITY OF NEW SOUTH WALES: APPOINTMENT OF PROFESSOR OF PHYSIOLOGY.

DR. P. KORNER, has been appointed Professor of Physiology in the new Medical School of the University of New South Wales. He has undertaken research into the effects of the lack of oxygen on circulation and related problems. Professor Korner graduated from the University of Sydney with first-class honours, and proceeded to two higher degrees (M.Sc. and M.D.). He was awarded a research fellowship by the National Health and Medical Research Council, and worked at Sydney Hospital with Professor F. C. Courtice. Later he spent two years in London with the Postgraduate Medical School, and eight months at the University of Harvard Medical School on a Life Assurance Travelling Fellowship from the Medical Research Foundation of Australia and New Zealand. Returning to Australia, he was appointed Senior Lecturer in Physiology at the University of Sydney, which position he held from 1956 to 1959, and in February, 1959, he was promoted to the Associate Professorship of Physiology.

## UNIVERSITY OF SYDNEY.

THE following appointments and promotions have been notified in *The Gazette, University of Sydney*, of April, 1960.

Dr. R. P. Shearman, a graduate in medicine and surgery of the University of Sydney, and previously Clinical Lecturer at the King George V Memorial Hospital and

## DISEASES NOTIFIED IN EACH STATE AND TERRITORY OF AUSTRALIA FOR THE WEEK ENDED APRIL 30, 1960.<sup>1</sup>

Disease.	New South Wales.	Victoria. <sup>2</sup>	Queensland.	South Australia.	Western Australia.	Tasmania.	Northern Territory.	Australian Capital Territory.	Australia. <sup>3</sup>
Acute Rheumatism .. ..	..	..	1	..	1	..	..	..	2
Amoebiasis .. ..	..	..	..	..	..	..	..	..	..
Ancylostomiasis .. ..	6	..	..	..	..	..	6	..	12
Anthrax .. ..	..	..	..	..	..	..	..	..	..
Bilharziasis .. ..	..	..	..	..	..	..	..	..	..
Brucellosis .. ..	..	..	..	..	..	..	..	..	..
Cholera .. ..	..	..	..	..	..	..	..	..	..
Chorea (St. Vitus) .. ..	..	..	..	..	..	..	..	..	..
Dengue .. ..	..	..	..	..	..	..	..	..	..
Diarrhoea (Infantile) .. ..	5(3)	..	6(2)	..	..	..	4	..	15
Diphtheria .. ..	..	..	..	1(1)	..	..	..	..	1
Dysentery (Bacillary) .. ..	..	..	1(1)	..	6(5)	..	1	6	15
Encephalitis .. ..	1(1)	..	..	1(1)	..	..	..	..	2
Filariasis .. ..	..	..	..	..	..	..	..	..	..
Homologous Serum Jaundice .. ..	..	..	..	..	..	..	..	..	..
Hydatid .. ..	..	..	..	..	..	..	..	..	..
Infective Hepatitis .. ..	48(21)	..	7(3)	14(10)	7(3)	..	..	4	80
Lead Poisoning .. ..	..	..	..	..	..	..	..	..	..
Leprosy .. ..	..	..	..	..	1(1)	..	..	..	..
Leptospirosis .. ..	..	..	..	..	..	..	..	..	..
Malaria .. ..	..	..	5(3)	..	..	1(1)	..	..	6
Meningococcal Infection .. ..	2(1)	..	..	..	..	..	..	..	2
Ophthalmia .. ..	..	..	..	..	5	..	..	..	5
Ornithosis .. ..	..	..	..	..	..	..	..	..	..
Paratyphoid .. ..	..	..	..	..	1(1)	..	..	..	1
Plague .. ..	..	..	..	..	..	..	..	..	..
Poliomyelitis .. ..	..	..	..	..	..	..	..	..	..
Pyrexial Fever .. ..	..	..	1	1(1)	..	..	1	..	2
Rubella .. ..	..	..	..	..	..	..	..	..	1
Salmonella Infection .. ..	..	..	..	..	..	..	..	..	..
Scarlet Fever .. ..	7(4)	..	..	3(3)	1(1)	..	..	..	11
Smallpox .. ..	..	..	..	..	..	..	..	..	..
Tetanus .. ..	..	..	..	..	2(1)	..	..	..	2
Trachoma .. ..	..	..	..	..	3	..	18	..	21
Trichinosis .. ..	..	..	..	..	..	..	..	..	..
Tuberculosis .. ..	39(26)	..	17(3)	7(4)	13(5)	2(1)	1	1	80
Typhoid Fever .. ..	..	..	..	..	..	..	..	..	..
Typhus (Flea-, Mite- and Tick-borne) .. ..	..	..	..	..	..	..	..	..	..
Typhus (Louse-borne) .. ..	..	..	..	..	..	..	..	..	..
Yellow Fever .. ..	..	..	..	..	..	..	..	..	..

<sup>1</sup> Figures in parentheses are those for the metropolitan area.

<sup>2</sup> Incomplete owing to absence of return from Victoria.

Tutor at The Royal Australasian College of Physicians, has been appointed Associate Professor of Obstetrics.

Mr. G. W. Milton, previously Senior Lecturer in Surgery, has been appointed Associate Professor of Surgery.

Dr. R. W. Cox, who holds the degrees of doctor of medicine of the University of New Zealand and doctor of philosophy of Oxford University, and who has had experience in private practice as a pathologist and teaching experience at Oxford University, has been appointed a Senior Lecturer in Pathology.

Dr. J. M. Nield, who holds the degrees of bachelor of medicine and bachelor of surgery of the University of Sydney, and who since 1958 has been Senior Surgical Registrar at the Prince of Wales General Hospital, London, has been appointed a Senior Lecturer in Anatomy.

Mr. J. P. Halliday, previously a Lecturer in Surgery, has been promoted to a Senior Lectureship.

Mr. W. E. Stehbins, previously a Lecturer in Pathology, has been promoted to a Senior Lectureship.

#### UNIVERSITY OF MELBOURNE: FACULTY OF MEDICINE.

Dr. Lucy M. Bryce has retired from membership of the Faculty of Medicine.

Dr. W. M. Lemmon, who for the past ten years has represented the honorary medical staff of the Royal Women's Hospital, Melbourne, on the Faculty of Medicine, has retired. He has been succeeded by Dr. D. F. Lawson.

Mr. A. R. Kelly has succeeded Dr. J. P. Horan as Dean of the Clinical School at St. Vincent's Hospital.

Dr. Luke Murphy has been appointed a member of the Faculty of Medicine.

Professor Sydney Sunderland, Dean of the Faculty of Medicine, has proceeded overseas and will be on leave until the end of the year. Professor Lance Townsend has been appointed Acting Dean for the remainder of 1960, and Professor L. J. Ray has been appointed Acting Professor of Anatomy during Professor Sunderland's absence.

### Notes and News.

#### Family Doctor.

*Family Doctor* continues to provide reading matter with a wide popular appeal, in which the philosophic pill is well gilded. As may be appreciated from the letters to the editor in any issue, the readers of this popular magazine find in it the answer to a number of health problems affecting both the senior and junior members of the family. They also find opinions and advice with which they express their disagreement forcefully in letters—an excellent way of promoting a lively and constructive debate. In the issue of March, 1960, attention is given to the problem of noise, to Caesarean section and to a number of other topical subjects, probably the most arresting of which is entitled "How to Keep Your Husband Alive". The April issue is largely devoted to the subject of road safety, attention being paid to everyone, of every age, who needs to be taught the basic principles. *Family Doctor* has something in it for everybody, and should be equally as acceptable in the doctor's waiting room as in the family living-room.

### Nominations and Elections.

THE undermentioned has applied for election as a member of the New South Wales Branch of the British Medical Association:

O'Malley, Terence, M.B., B.S., 1959 (Univ. Sydney), 41 Harden Street, Artarmon.

### Deaths.

THE following deaths have been announced:

FLETCHER.—Malcolm Weld Fletcher, on May 13, 1960, at Launceston.

SHEARMAN.—Cyril Howard Shearman, on May 20, 1960, at Bellevue Hill.

PATON.—James Thompson Paton, on May 22, 1960, at Orange.

### Diary for the Month.

JUNE 7.—New South Wales Branch, B.M.A.: Organization and Science Committee.

JUNE 9.—New South Wales Branch, B.M.A.: Public Relations Committee.

JUNE 10.—Tasmanian Branch, B.M.A.: Branch Council.

JUNE 10.—Queensland Branch, B.M.A.: Council Meeting.

JUNE 13.—Victorian Branch, B.M.A.: Finance Subcommittee.

JUNE 14.—New South Wales Branch, B.M.A.: Executive and Finance Committee.

### Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Medical Secretary, 135 Macquarie Street, Sydney): All contract practice appointments in New South Wales.

South Australian Branch (Honorary Secretary, 80 Brougham Place, North Adelaide): All contract practice appointments in South Australia.

### Editorial Notices.

ALL articles submitted for publication in this Journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations, other than those normally used by the Journal, and not to underline either words or phrases.

Authors of papers are asked to state for inclusion in the title their principal qualifications as well as their relevant appointment and/or the unit, hospital or department from which the paper comes.

References to articles and books should be carefully checked. In a reference to an article in a journal the following information should be given: surname of author, initials of author, year, full title of article, name of journal, volume, number of first page of article. In a reference to a book the following information should be given: surname of author, initials of author, year of publication, full title of book, publisher, place of publication, page number (where relevant). The abbreviations used for the titles of journals are those of the list known as "World Medical Periodicals" (published by the World Medical Association). If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

Authors submitting illustrations are asked, if possible, to provide the originals (not photographic copies) of line drawings, graphs and diagrams, and prints from the original negatives of photomicrographs. Authors who are not accustomed to preparing drawings or photographic prints for reproduction are invited to seek the advice of the Editor.

Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary is stated.

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